Alternative Benefit Plan

State Name: Louisiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: LA - 16 - 0005 | OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Bayou Health

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Alternative Benefit Plan

State Name: Louisiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

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Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	**ABP2a**
The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.	Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

Louisiana Medicaid has fully aligned the benefits in the ABP with its approved Medicaid State Plan by using duplication, substitution and including remaining Medicaid State Plan services as other Section 1937 covered benefits while still meeting the requirements of all Essential Health Benefits.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

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Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Bayou Health

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ◉ The state/territory offers benefits based on the approved state plan.
  - ○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ◉ The state/territory offers the benefits provided in the approved state plan.
    - ○ Benefits include all those provided in the approved state plan plus additional benefits.
    - ○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ○ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

ABP benefits and limitations are commensurate with the State Plan.

Selection of Base Benchmark Plan

Alternative Benefit Plan

State Name: Louisiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

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Alternative Benefit Plan Cost-Sharing	ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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Benefits Description — ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue Cross and Blue Shield Service Benefit Plan - Basic Option (FEHBP)

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services — Collapse All ☐

Benefit Provided: Outpatient Hospital Services
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Family Planning Services & Supplies
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services include all approved pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the FDA.

Benefit Provided: Physician's Services
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit:
Services must be within scope of practice of medicine, optometry, osteopathy as defined by State law or under personal supervision of person licensed under State law to practice medicine or osteopathy.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Medical & Surgical Services by a Dentist

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: None

Scope Limit: dental services provided on inpatient basis must be PA'd. Reimbursement limited to those services involving diseases or conditions of the head and neck commonly accepted as being within the scope of the practitioner's training and expertise.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Licensed Practitioners - Podiatrists

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: limited to Health Care Procedural Codes they are licensed to perform under State law and covered Medicaid as Physician's services

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Home Health - Intermittent and Part-time Nursing

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Other Licensed Practitioners - Physician Assistant

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
none

Scope Limit:
Service coverage determined by individual licensure, scope of practice, and delegation by supervising physician.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Other Licensed Practitioner - Clinical Nurse Spec.

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Service coverage determined by individual licensure, scope of practice, and terms of the physician collaboration agreement.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Other Licensed Practitioners - CRNA

Source:
State Plan 1905(a)

Remove

Alternative Benefit Plan

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services limited to anesthesia services provided in accordance with State law reimbursable to CRNA's.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Clinic Services - Dialysis

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: There are no limits for covered services that meet medical necessity

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Clinic Services: Radiation Therapy

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: No limits for covered services that meet medical necessity

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Alternative Benefit Plan

Benefit Provided: Clinic Svs: Ambulatory Surgical Center

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: services must be medically necessary, non-emergent, and not requiring an overnight stay.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Certified Pediatric or Family Nurse Practitioner

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Service coverage determined by individual licensure, scope of practice, and terms of physician collaboration agreement.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Hospice

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Respite care, continuous home care are limited

Duration Limit: none

Scope Limit: A prognosis of terminal illness is required. Services are for the palliation or management of terminal illness and related conditions.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Core services include medical social services, counseling services, dietary counseling including training the family/caregivers in preparation and provision of meals, bereavement counseling for the terminally ill patient and family, both pre and post-death up to 1 year, pastoral care including clergy, and any other counseling services as determined by the hospice.

Home health aide and homemaker are available if in the Plan of Care.

Physical therapy, occupational therapy, and speech-language pathology services are available if in the Plan of Care.

Short-term inpatient care in a participating hospice inpatient unit may be provided if services meet the written plan of care.

General inpatient care is provided for procedures necessary for pain control or acute chronic symptom management which cannot be provided in other settings.

Medical appliances, supplies, drugs and biologicals, for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances include covered DME as well as other self-help and personal comfort items related to the palliation or management of the recipient's terminal illness and related conditions. Equipment is provided by the hospice for use in the home while he or she is under hospice care.

Any other covered item or service that is necessary for the palliation and management of the terminal illness and related conditions and is on the Plan of Care.

Inpatient Respite limited to 5 days per election period (initial 90 day, subsequent 90 day; unlimited 60 day periods). These election periods may be used consecutively or at different times during the recipient's lifespan.

Inpatient care is available to the recipient for the purpose of pain control or acute or chronic symptom management which cannot be managed in other settings.

Routine home care is available for a recipient who is at home and is not receiving continuous home care.

Continuous home nursing care is furnished during brief periods of medical crisis to maintain the recipient at home. This service is primarily nursing care to achieve palliation or management of acute medical symptoms. Services are provided by a Registered Nurse or licensed practical nurse for more than half of the period of care.

Children are included in the hospice benefit and must receive curative care concurrently for the terminal condition at the same time as receiving hospice. Recipients under the age of 21 must receive daily visits when in the home and must have all care coordinated.

During the time of hospice election, the recipient must be provided services comparable to other services s/ he received through Medicaid prior to electing hospice, including pharmaceutical and biological services and durable medical equipment.

Alternative Benefit Plan

Benefit Provided: OLP - Audiologist

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: none

Scope Limit: diagnostic, preventive or corrective services for persons with speech, hearing and language disorders

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

PA is required only when this service is delivered as an outpatient hospital service.

Benefit Provided: Non-Emergency Medical Transportation

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: To and from medical provider for covered service

Duration Limit: None

Scope Limit: Least expensive transportation suitable to meet beneficiary's medical needs

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Transportation generally requires a two (2) day notice in order to arrange transportation; however, Louisiana Medicaid will attempt to arrange NEMT even if two days' notice is not given.

All other avenues of providing transportation appropriate to meet the beneficiary's needs have been explored and have been found unavailable - this includes family, friends, community resources, transportation by the parish Medicaid office or other State or Federally funded transportation resources.

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Outpatient Hospital services - emergency care
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Ambulance
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: none
Duration Limit: none
Scope Limit: Services are available for unforeseen circumstances which apparently demand immediate attention at hospital to prevent serious impairment or loss of life.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior Authorization is required only for air ambulance

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization

Collapse All ☐

Remove

Benefit Provided:
Inpatient Hospital Services

Source:
State Plan 1905(a)

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Excludes care which can be provided at home, an ICF/DD or Skilled Nursing facility; or which the primary purpose is for convalescent care, rest or cosmetic care; or diagnostic/ surgical procedures when such can be performed on outpatient basis.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services require prior authorization such as Outpatient surgery performed Inpatient, Organ Transplants, Cochlear Implants (under age 21), Intrathecal Bachlofen Therapy, and Out-of-State Non-Emergency Hospitalization.

Services include any essential medical care that in the judgment of the attending physician or by a dentist is needed for the treatment of illness or injury which can be provided safely and adequately only in a hospital and includes basic services the hospital is expected to provide.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Inpatient Hospital (Maternity)
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Elective deliveries under 39 weeks are not covered
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Physician Services (Maternity)
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Elective deliveries under 39 weeks are not covered
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Nurse Midwife Services
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Limited by individual licensure, scope of practice, and terms of the physician collaborative agreement.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Service coverage determined by individual licensure, scope of practice and terms of physician collaborative agreement.

Add

Alternative Benefit Plan

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided: Inpatient Hospital Service - MH-SUD
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Services cannot be delivered in an IMD
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Hospital Services - MH/SUD
Source: State Plan 1905(a)
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services which require prior authorization include psych testing, and electroconvulsive treatment.

Benefit Provided: Physician Services - MH/SUD
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Rehabilitation Services - SU Addiction

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: requires annual redetermination of trmt plan

Scope Limit: Services cannot be delivered in an IMD

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Services include individual or group therapy, may include outpatient and residential services . Only Intensive Outpatient and Residential services require Prior Authorization.

Benefit Provided: Other Licensed Practitioners - LMHP svs. MH/SUD

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Rehabilitation Services - Mental Health

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services are Prior Authorized except Crisis Intervention.

Add

☒ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of Louisiana's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for Prescribed Drugs.
The State has procedures in place that allow an enrollee to gain access to clinically appropriate drugs in excess of the four (4) prescription limit per month, when the prescriber attests that the prescription is medically necessary and provides a diagnosis code.

Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All

Benefit Provided: PT, OT, ST, Audiology - Outpatient hospital
Source: State Plan 1905(a)
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
This benefit is provided for rehabilitative and habilitative services.

Benefit Provided: Home Health - PT, OT, Speech and Audiology
Source: State Plan 1905(a)
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Physical therapy: treatment of patient's illness or injury, or restoration and maintenance of function

Occupational Therapy: treatment to improve or restore a function which has been impaired by illness or injury or improve the individual's ability to perform the tasks required for independent functioning when the functioning has been permanently lost or reduced by illness or injury.

speech and audiology - services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities, and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of a communication disability.

Benefit Provided: Prosthetic Devices
Source: State Plan 1905(a)
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
least costly most effective treatment

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Prosthetic supplies and equipment are not rented or purchased for an individual in a hospital; upon discharge, if the item is included in the plan, the items are provided in the outpatient setting. Prosthetic equipment and appliances are considered for rental, purchase or repair when the item is medically necessary by a recipient who has a serious impairment to enhance well-being, prevent further impairment, or increase self-care or reduce care provided by others, the item is not available through another agency at no cost, is covered by Medicaid, and is primarily medical in nature and not a convenience item.

Benefit Provided:
Home Health: Med Supplies, Equipment & Appliances

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
least costly most effective treatment; suitable for use in the home which does not include a hospital or nursing facility

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Includes purchase, rental and repair. Supplies and equipment are not rented or purchased in a hospital; upon discharge, if included in the plan they will be provided in the outpatient setting. Medical supplies, equipment and appliances are considered for rental, purchase or repair when the item is medically necessary by a recipient who has a serious impairment to enhance well-being, prevent further impairment, or increase self-care or reduce care provided by others, the item is not available through another agency at no cost, is covered by Medicaid, and is primarily medical in nature and not a convenience item.

Benefit Provided:
Home Health Aide

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services cannot be provided in a hospital or nursing facility.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These are direct care services provided under the supervision of a registered nurse in compliance with the standards of nursing practice governing delegation, which include assistance with the activities of daily living such as mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, or toileting.

Add

Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services — Collapse All

Benefit Provided: Other Lab and X-Ray Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: none

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes a broad range of preventive services including "A" and "B" services recommended by the US Preventive Services Task Force, Advisory Committee for Immunization Practices (ACIP) recommended vaccines, preventive care and screening for infants, children and adolescents recommended by HRSA's Bright Futures program/project and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Tobacco cessation

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: none

Scope Limit: none

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

services include over-the-counter and prescription medications for which the individual has a prescription, and toll-free referral assistance

Add

Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
up to age 21

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Authorization may be required for services in excess of limits and for services not available to adults. The State will provide other health care described in Section 1905(a) of the Social Security Act that is found to be medically necessary to correct or ameliorate defects as well as physical and mental illnesses and conditions discovered by the screening service even when such health care is not otherwise covered under the State Plan.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted:	Source:	
Allergy Care	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Louisiana Medicaid State Plan as Physician's services in EHB 1: Ambulatory patient services

Base Benchmark Benefit that was Substituted:	Source:	
Anesthesia	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Louisiana Medicaid State Plan as Physician Services, and Other Licensed Practitioners: CRNA in EHB 1: Ambulatory patient services.

Base Benchmark Benefit that was Substituted:	Source:	
Diagnostic and Treatment Services	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under La. Medicaid State Plan as Physicians' Services, Physicians' Assistants, and Certified Pediatric or Family Nurse Practitioner Services in EHB 1: Ambulatory Patient Services

Base Benchmark Benefit that was Substituted:	Source:	
Educational Classes and Programs-Tobacco Cessation	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Tobacco cessation covered under the La. Medicaid State Plan in EHB 9: Preventive and wellness services and chronic disease management; and EHB 6: Pharmacy.

Base Benchmark Benefit that was Substituted:	Source:	
Family Planning	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under La. Medicaid State Plan as Family Planning Services and Supplies in EHB 1: Ambulatory patient services. The La. Medicaid State Plan coverage for Family Planning is at least as rich as the base benchmark.

Base Benchmark Benefit that was Substituted:	Source:	
Foot care	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Other Licensed Practitioners - Podiatrists' services and Physician Services in EHB 1: Ambulatory patient services. The base benchmark benefit for Foot care is routine foot care only when an individual is under active treatment for a metabolic or peripheral vascular disease, such as diabetes. The La. Medicaid State Plan coverage for OLP Podiatrists services is at least as rich as the base benchmark coverage for Foot Care.

Base Benchmark Benefit that was Substituted: Home Health Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Home Health - Intermittent and Part-Time Nursing Services (7.a) in EHB 1: Ambulatory patient services. The La. Medicaid State Medicaid plan is more generous that the base benchmark which only covers home nursing for 2 hours per day up to 25 visits per calendar year. The La. Medicaid State Plan for Home Health services is at least as rich, or richer than the base benchmark.

Base Benchmark Benefit that was Substituted: Oral and Maxillofacial Surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Medical and Surgical Services by a Dentist in EHB 1: Ambulatory patient services.

Base Benchmark Benefit that was Substituted: Outpatient Hospital or Ambulatory Surgical Center

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Outpatient Hospital Services and Clinic Services: Ambulatory Surgery Centers in EHB 1: Ambulatory patient services.

Base Benchmark Benefit that was Substituted: Surgical Procedures

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Physicians' Services in EHB 1: Ambulatory patient services

Base Benchmark Benefit that was Substituted: Treatment Therapies

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Outpatient Hospital Services, Clinic Services: Dialysis and Clinic Services: Radiation in EHB 1: Ambulatory patient services.

Base Benchmark Benefit that was Substituted:	Source:	
Alternative Treatments - Acupuncture	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Non-Emergency Medical Transportation under La. Medicaid State Plan covered under the La. Medicaid State Plan and found in EHB 1.

Base Benchmark Benefit that was Substituted:	Source:	
Chiropractic	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Non-Emergency Medical Transportation covered under the La. Medicaid State Plan and found in EHB 1. (The base benchmark covers only 1 office visit per calendar year and one set of X-rays per calendar year.)

Base Benchmark Benefit that was Substituted:	Source:	
Infertility Services	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under La. Medicaid State Plan under multiple benefits as Physician Services in EHB 1: Ambulatory patient services; Prescribed drugs in EHB 6: Pharmacy services; and EHB 3: Inpatient Hospital Services. Base benchmark coverage is limited to diagnosis and coverage of non-ART treatment of infertility. The La. Medicaid State Plan for Infertility Services is at least as rich as the base benchmark.

Base Benchmark Benefit that was Substituted:	Source:	
Manipulative Treatment	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Non-Emergency Medical Transportation services covered under the La. Medicaid State Plan and found in EHB 1. (Base benchmark is limited to 20 visits per year.)

Base Benchmark Benefit that was Substituted:	Source:	
Accidental Injury	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under La. Medicaid State Plan as Outpatient Hospital Services - Emergency in EHB 2 and Inpatient Hospital Services in EHB 3.

Base Benchmark Benefit that was Substituted:	Source:	
Medical Emergency	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan Outpatient Hospital Services - Emergency in EHB 2.

Base Benchmark Benefit that was Substituted:	Source:	
Ambulance	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as ambulance in EHB 2: Emergency Services

Base Benchmark Benefit that was Substituted:	Source:	
Reconstructive Services	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Inpatient Hospital services in EHB 3: Hospitalization. (Neither base benchmark nor La. Medicaid cover cosmetic surgery)

Base Benchmark Benefit that was Substituted:	Source:	
Organ/Tissue Transplants	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the La. Medicaid State Plan as Inpatient Hospital Services in EHB 3: Hospitalization.

Base Benchmark Benefit that was Substituted:	Source:	
Inpatient Hospital Services	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Inpatient Hospital Services in EHB 3: Hospitalization

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Maternity Care
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the La. Medicaid State Plan as Inpatient Hospital Services (Maternity); Physician Services- Maternity, Other Licensed Practitioners - Nurse Midwife, Nurse Midwife Services, all in EHB 4: Maternity and Newborn Care.

Base Benchmark Benefit that was Substituted: Professional Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Outpatient Hospital Services -MH/SUD, Physicians' Services - MH/SUD, Other Licensed Practitioners - LMHP, and rehabilitation services - addiction SUD, all in EHB 5: Mental Health/Substance Use. The La. Medicaid State Plan is at least as rich as the base benchmark.

Base Benchmark Benefit that was Substituted: Inpatient Hospital or Other Covered Facility
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under La. Medicaid State Plan as Inpatient Hospital Services EHB 5: Mental Health/ Substance Use.

Base Benchmark Benefit that was Substituted: Outpatient Hospital or Other Covered Facility
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under La. Medicaid State Plan as Outpatient Hospital Services in EHB 5: MH/SUD.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Home Health Services Medical Supplies, Equipment and Appliances in EHB 7: Rehabilitative and Habilitative Services and Devices. The La. Medicaid State Plan is at least as rich as, if not richer than the base benchmark.

Base Benchmark Benefit that was Substituted: Medical Supplies
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Home Health Services Medical Supplies, Equipment and Appliances in EHB 7: Rehabilitative and Habilitative Services and Devices. The La. Medicaid State Plan is at least as rich as, if not richer than the base benchmark.

Base Benchmark Benefit that was Substituted: Orthopedic and Prosthetic Devices

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under La. Medicaid State Plan as Prosthetic Devices EHB 7:Rehabilitative and Habilitative Services and Devices. The La. Medicaid State Plan is at least as rich as, if not richer than the base benchmark.

Base Benchmark Benefit that was Substituted: Physical, Occupational, Speech, Cognitive Therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under La. Medicaid State Plan as Physical Therapy, Occupational Therapy, Speech Pathology and Audiology services provided under Outpatient hospital services in EHB 7: Rehabilitative and habilitative services. Audiology also provided under Physician services in EHB 1. Services in La. Medicaid have no limits on amount or scope. Coverage under Louisiana Medicaid is richer than the base benchmark benefit which has a combined limit of 50 visits per person per calendar year.

Base Benchmark Benefit that was Substituted: Lab, X-Ray, and Other Diagnostic Tests

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under La. Medicaid State Plan as Other Laboratory and X-ray Services in EHB 8: Laboratory Services.

Base Benchmark Benefit that was Substituted: Preventive Care Services for Children and Adults

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Preventive Services in EHB 9: Preventive and Wellness Services and Chronic Disease Management; and EPSDT in EHB 10: Pediatric Services including Oral and Vision Care

Base Benchmark Benefit that was Substituted: Covered Medication and Supplies

Source: Base Benchmark

Remove

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Prescribed Drugs in EHB 6: Prescription Drugs.

Base Benchmark Benefit that was Substituted:	Source:	
Hearing Services (Testing, Treatment, Supplies)	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under La. Medicaid State Plan as Outpatient Hospital Services and Audiology services in EHB 1: Ambulatory Patient Services; and Home Health - Audiology in EHB 7; Rehabilitative and Habilitative Services. Base benchmark only covers tests related to illness and injury but not for routine hearing tests for adults. The La. Medicaid State Plan coverage for hearing services is at least as rich as the base benefit.

Base Benchmark Benefit that was Substituted:	Source:	
Cardiac rehabilitation	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Home Health Aide Services from Louisiana Medicaid State Plan in EHB 7: Rehabilitative and Habilitative Services and Devices. There are no limitations to home health aide visits.

Base Benchmark Benefit that was Substituted:	Source:	
Pulmonary Rehabilitation	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Home Health Aide Services from Louisiana Medicaid State Plan in EHB 7: Rehabilitative and Habilitative Services and Devices. There are no limitations to home health aide visits.

Base Benchmark Benefit that was Substituted:	Source:	
Wigs due to chemotherapy hair loss	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Home Health Aide Services from Louisiana Medicaid State Plan in EHB 7: Rehabilitative and Habilitative Services and Devices. There are no limitations to home health aide visits.

Base Benchmark Benefit that was Substituted:	Source:	
Hospice	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Louisiana Medicaid State Plan as Hospice Care in EHB 1: Ambulatory patient

services. La. Medicaid State Plan coverage for hospice is at least as rich, if not richer than the benchmark. La. Medicaid provides routine home care, continuous home care (nursing) during periods of medical crisis, as necessary. Homemaker and home health aide services are available. Benchmark limits home service to 7 consecutive days and 30 consecutive days in facility. Base benchmark allows for 7 days in inpatient hospice facility to provide caregiver respite. Base benchmark does not provide homemaker services, bereavement care, pre- and post death, or pastoral care.

Base Benchmark Benefit that was Substituted: Intensive Outpatient Services - Mental Health

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Louisiana Medicaid State Plan as Rehabilitation Services - Mental Health in EHB 5: Mental Health and substance use disorder services including behavior health treatment.

Base Benchmark Benefit that was Substituted: Partial Hospitalization - Mental Health

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Louisiana Medicaid State Plan as Rehabilitation Services - Mental Health in EHB 5: Mental Health and substance use disorder services including behavior health treatment.

Base Benchmark Benefit that was Substituted: Educational Classes & Programs-Diabetic Education

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Physician Services, Outpatient Hospital Services in EHB 1: Ambulatory patient services.

Base Benchmark Benefit that was Substituted: Hearing Aids

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Home Health Aide Services from Louisiana Medicaid State Plan in EHB 7: Rehabilitative and Habilitative Services and Devices. There are no limitations to home health aide visits. Hearing Aids in the benchmark are limited to $1250 per ear every 36 months.

Base Benchmark Benefit that was Substituted: Intensive Outpatient Treatment - SUD

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Rehab Services - Addiction Substance Use Disorder EHB 5.

Base Benchmark Benefit that was Substituted:	Source:	
Partial Hospitalization - SUD	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the La. Medicaid State Plan as Rehab Services - Addiction Substance Use Disorder EHB 5.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered — Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Routine Adult Vision Services

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Routine, non-pediatric eye exam services are an excepted benefit pursuant to 45 CFR 156.115(d)

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Routine Adult Dental Benefit

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Routine, non-pediatric dental services are an excepted benefit pursuant to 45 CFR 156.115(d)

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Other 1937 Benefit Provided: Telemedicine

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: none

Scope Limit: None

Other: Prior Authorization not required.

Other 1937 Benefit Provided: FQHC/RHC Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Physician, P.A., Nurse Practitioner, Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Dentist and services incidental thereto; and other ambulatory services.

Other: Prior Authorization not required.

Other 1937 Benefit Provided: Other Licensed Practitioners - Optometrist

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: none

Scope Limit: Services may be provided to the same extent and according to same standards as physician services who perform eye services

Other:

Prior Authorization not required.

Other 1937 Benefit Provided:

Extended Services for Pregnant Women

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

once per pregnancy or once per 270 days

Duration Limit:

none

Scope Limit:

screening and intervention services limited to pregnant women

Other:

Screening and Intervention services that are medically necessary for pregnant women for the use of alcohol, tobacco, drugs, or domestic violence. If miscarriage or fetal death occurs within 270 days, a screening/intervention will be allowed for subsequent pregnancy.

Other 1937 Benefit Provided:

Skilled Nursing Facility Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services cannot be provided in an IMD. Coverage is limited to services provided in facilities certified by under Title XIX.

Other:

Other 1937 Benefit Provided:

Intermediate Care Facility/IDD Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Alternative Benefit Plan

Scope Limit:

Services cannot be provided in an IMD. Services do not include vocational or developmental evaluations, or voice evaluations or voice therapy unless the recipient is under the age of 21.

Other:

Coverage is limited to services provided in Title XIX certified ICF facilities and with any licensing requirements required by the State.

Other 1937 Benefit Provided:

Medical and Remedial Care and Svs - Dentures

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 complete or partial per 8 year period

Duration Limit:

none

Scope Limit:

Services limited to 1 complete or partial denture per arch in an 8 year period. A combination of 2 complete or partial denture relines per arch or 1 complete or partial denture and 1 reline per arch is allowed in an 8 year period.

Other:

Other 1937 Benefit Provided:

Tuberculosis Control Center Clinic

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

limited to persons infected with Tuberculosis.

Other:

Prior Authorization not required.

Other 1937 Benefit Provided:

Prenatal Health Care Center Clinics

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
none

Duration Limit:
pregnancy and 1 post-partum visit

Scope Limit:
prenatal care, unlimited once medical establishment of pregnancy established. Includes including risk assessments for high risk pregancies; 1 post partum visit

Other:
medical establishment of pregnancy required

Other 1937 Benefit Provided:
Sexually Transmitted Disease Control Clinic

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
none

Duration Limit:
none

Scope Limit:
none

Other:
no PA required

Other 1937 Benefit Provided:
OLP - Pharmacists/Medication Administration

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Administration of influenza vaccine

Other:
Prior Authorization is not required.

Alternative Benefit Plan

Other 1937 Benefit Provided: PACE

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Restricted to persons age 55 and above, meeting Nursing Facility Level of Care and geographically located.

Other: Requires meeting Nursing Facility level of care and living in certain Zip Codes within State; meeting income and resource restrictions

Other 1937 Benefit Provided: Out-of-State Non-Emergency Hospitalizations

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: Louisiana Medicaid provides out-of-state non-emergency hospitalization for Medicaid enrollees.

Other 1937 Benefit Provided: Free Standing Birthing Centers

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: stays less than 24 hrs

Scope Limit: None

Other: Prior Authorization is not required. The Free Standing Birthing Center shall be located within a ground

travel time distance from a general acute care hospital with which the FSBC has a contractual relationship which includes a transfer agreement which allows for a caesarian delivery to begin within 30 minutes of the decision to that such a delivery is necessary.

Other 1937 Benefit Provided:
Personal Care Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
cannot exceed 32 hrs. per week

Duration Limit:
none

Scope Limit:
Individual cannot be an inpatient, resident of hospital, nursing facility, ICF/DD or IMD

Other:
Services which enable an individual whose needs would otherwise require placement in an acute or long term care facility to remain safely in his/her home. Services include assistance with activities of daily living and the instrumental activities of daily living.

Other 1937 Benefit Provided:
Directly Observed Therapy-Tuberculosis

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
until disease arrested

Scope Limit:
Direct observation by health care professional to assure medication taken. follows medicinal administration schedule which is typically 1x per day for first 14 days, and then 2 x per week until arrested, typically between 6 mo. and 1 year

Other:
Service is limited to persons who are infected with Tuberculosis meet program requirements. Patient must also be "non-compliant" such that health care professional deems completion of treatment regimen necessary.

Other 1937 Benefit Provided:
Nursing Facility Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

24 hour care for rehabilitative, restorative and skill nursing care for recipients needing assistance with activities of daily living.

Other:

Only Medicaid-certified nursing facilities may admit recipients

Requires an order from a licensed physician for admission

Pre-admission screenings and resident reviews (Level 1and Level II PASRR) are conducted to determine whether the applicant/recipient has a diagnosis of serious mental illness or intellectual disability and to determine whether the applicant/resident requires nursing facility services and/or specialized services for his/her mental condition.

Additionally, a Level of Care determination must be conducted for any recipient seeking admittance to determine if he/she meets the nursing facility Level of Care.

Services include assistance with Activities of Daily Living such as bathing, dressing, transferring, toileting, and eating, specialized services if determined through a Level II PASRR, as well as skilled nursing

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Alternative Benefit Plan

State Name: Louisiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: LA - 16 - 0005 | OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

- [x] The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- [x] The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- [x] The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- [x] The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- [x] The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- [x] The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Louisiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: LA - 16 - 0005 | OMB Expiration date: 10/31/2014

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [x] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

Members who will be given the opportunity during completion of the Medicaid application to select from among five MCOs. Members who are being automatically transitioned from Family Planning State Plan services (Take Charge Plus Program) or the Greater New Orleans Community Health Connection (GNOCHC) Section 1115 Demonstration Waiver will be auto-assigned to an MCO by the State's conflict-free Enrollment Broker. All members will have 90 days from initial MCO assignment to select a different MCO, and choice counseling in selecting the Plan that best fits the member's needs is available through the Enrollment Broker and website www.bayouhealth,com.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ◉ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.

Alternative Benefit Plan

○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: 11/10/2011

Describe program below:

Louisiana Medicaid's managed care program, called Bayou Health, is comprised of five managed care organizations who are responsible for overseeing the delivery of comprehensive, integrated physical and behavioral health (basic and specialized) services statewide for Medicaid enrollees utilizing a risk bearing model.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

○ Section 1915(a) voluntary managed care program.

◉ Section 1915(b) managed care waiver.

○ Section 1115 demonstration.

○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: 06/01/2014

Describe program below:

Single statewide dental benefit manager for dental services and adult denture benefits.

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Louisiana Medicaid State Plan Services that are excluded from MCO benefits and services, and that continue to be traditional state-managed fee-for-service services. They are Applied Behavior Analysis-Based Therapy (limited to 19 and 20 year olds), nursing facility care (ages 21-64) and Long-Term Personal Care Services (Age 21-64)

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140417

Alternative Benefit Plan

State Name: Louisiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: LA - 16 - 0005 | OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

V 20140415

Alternative Benefit Plan

State Name: Louisiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: LA - 16 - 0005 | OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

Alternative Benefit Plan

State Name: Louisiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: LA - 16 - 0005 | OMB Expiration date: 10/31/2014

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

V.20140415

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

February 10, 2016

Karen Matthews, Health Director
Chitimacha Health Clinic
3231 Chitimacha Trail
Jeanerette, LA 70544

Angela Martin
Chitimacha Tribe of Louisiana
P. O. Box 640
Jeanerette, LA 70544

Anita Molo
Chitimacha Tribe of Louisiana
P. O. Box 640
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Marshall Pierite, Chairman
Misty Hutchby, Health Director
Tunica-Biloxi Tribe of Louisiana
P. O. Box 1589
Marksville, LA 71351-1589

Lovelin Poncho, Chairman
Paula Manuel, Health Director
Coushatta Tribe of Louisiana
P. O. Box 818
Elton, LA 70532

Chief Beverly Cheryl Smith
Holly Vanhoozen, Health Director
The Jena Band of Choctaw Indians
P. O. Box 14
Jena, LA 71342

Dear Louisiana Tribal Contact:

RE: Notification of Louisiana Medicaid State Plan Amendments

In compliance with the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009, the Department of Health and Hospitals, Bureau of Health Services Financing is taking the opportunity to notify you of State Plan amendments (SPAs) that may have an impact on your tribe.

Attached for your review and comments is a summary of the proposed State Plan amendments. Please provide any comments you may have by March 11, 2016 to Mrs. Darlene Budgewater via email to Darlene.Budgewater@la.gov or by postal mail to:

Department of Health and Hospitals
Bureau of Health Services Financing
Medicaid Policy and Compliance
P.O. Box 91030
Baton Rouge, LA 70821-9030

Should you have additional questions about Medicaid policy, Mrs. Budgewater will be glad to assist you. You may reach her by email or telephone at (225) 342-3881. Thanks for your continued support of the tribal consultation process.

Sincerely,

Darlene A Budgewater

for Jen Steele
Interim Medicaid Director

Attachment (1)

JS/DB/ZPK

c: Ford J. Blunt, III
Stacey Shuman

State Plan Amendment for submittal to CMS

Request for Tribal Comments
February 10, 2016

Managed Care for Physical and Behavioral Health - Expansion Under the Affordable Care Act

The SPA proposes to revise the provisions governing managed care for physical and behavioral health to enroll the new adult group into Bayou Health managed care organizations (MCOs). Recipients who enroll with a health plan will have their Medicaid covered services coordinated through Bayou Health.

Medicaid Eligibility – Expansion Under the Affordable Care Act

The SPA proposes to revise the provisions governing Medicaid eligibility in order to adopt provisions in the Medicaid Program to expand coverage to the new adult group, individuals from age 19 to 65 years old at or below 133 percent of the Federal Poverty Level with a 5 percent income disregard.

Medicaid Expansion Under the Affordable Care Act

The SPA proposes to adopt provisions in the Medicaid Program to:
1) expand Medicaid coverage to individuals from age 19 to 65 years old at or below 133 percent of the Federal Poverty Level with a 5 percent income disregard as provided in 42 CFR 435.119;
2) implement a Secretary-approved coverage option which incorporates the benefits and services covered under the Medicaid State Plan, including the essential health benefits as provided in §1302(b) of ACA;
3) use the Basic Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program as the state's benchmark benefit package; and
4) establish provisions for the use of the Supplemental Nutrition Assistance Program (SNAP) option for streamlined enrollment of SNAP recipients who meet eligibility requirements for the new adult group.

Total FY 17-18 cost: $34,114,285
Total FY 17-18 net savings (including premium tax revenues): $29,972,176

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in the following impact on revenue collections:

FY 15-16

1. Increase federal revenue collections by approximately $7,318,130 for administrative costs;
2. Increase other revenue collections (provider donations through statutory dedicated funding) by approximately $2,999,458 to fund the required state match for administrative costs;
3. Increase federal revenue collections by approximately $270 for the federal share of promulgation costs for this proposed rule and the final rule

Total FY 15-16 Revenue Collections: $10,317,858

FY 16-17

1. Increase federal revenue collections by approximately $24,793,987 for administrative costs and $1,815,174,258 for programmatic costs;
2. Reduce federal revenue collections by approximately $114,981,077 for refinanced programmatic expenditures and DSH payment reductions;
3. Increase other revenue collections (premium tax revenues) by approximately $26,372,598 which will be used to fund the required state match for programmatic and administrative costs;

Total FY 15-16 Revenue Collections: $1,751,359,765

FY 17-18

1. Increase federal revenue collections by approximately $26,387,143 for administrative costs and $2,271,127,904 for programmatic costs;
2. Reduce federal revenue collections by approximately $236,357,740 for refinanced programmatic expenditures and DSH payment reductions
3. Increase other revenue collections (premium tax revenues) by approximately $64,086,462 which will be used to fund the required state match for programmatic and administrative costs;

Total FY 15-16 Revenue Collections: $2,125,243,769

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule amends the provisions governing Medicaid eligibility to adopt provisions in the Medicaid program to expand coverage to the new adult group under the provisions of the Affordable Care Act. It is anticipated that implementation of this proposed rule will increase programmatic expenditures (inclusive of administrative costs) in the Medicaid Program by $10,317,588 in FY 15-16, $1,741,396,617 in FY 16-17 and $2,095,271,593 in FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule may have a positive effect on competition and employment. Medicaid expansion in Louisiana is expected to increase the gross state product which will foster an increase in economic activity, including an increase in revenue for providers and health care partners. The increase in payments may improve the financial standing of providers and could possibly cause an increase in employment opportunities. Medicaid expansion may also potentially increase the competition between managed care organizations and participating providers.

Jen Steele
Interim Medicaid Director
1602#069

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Medicaid Expansion under the Affordable Care Act
(LAC 50:I.Chapters 101-103)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt LAC 50:I.Chapters 101-103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Patient Protection and Affordable Care Act (P.L. No. 111-148), hereafter referred to as the Affordable Care Act (ACA), and §1937 of Title XIX of the Social Security Act (SSA) provides states with the option to expand Medicaid coverage to individuals from age 19 to 65 years old at or below 133 percent of the federal poverty level with a 5 percent income disregard as provided in 42 CFR 435.119, hereafter referred to as the new adult group.

Under the provisions of §1937 of the SSA, state Medicaid programs have the option to provide enrollees with "benchmark" or "benchmark-equivalent" coverage based on one of three commercial insurance products, or a fourth Secretary-approved coverage option which can include the Medicaid State Plan benefit package offered in their state. "Benchmark" benefits are those that are at least equal to one of the statutorily specified benchmark plans, and "benchmark-equivalent" are those benefits that include certain specified services, and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages. Federal regulations under ACA also stipulate that the packages must cover essential health benefits as designated in §1302(b) of ACA which includes 10 specific benefit categories.

The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) has directed states that wish to expand Medicaid coverage to the new adult group to submit state plan amendments (SPAs) to secure approval for implementation. In compliance with CMS' directive and federal regulations, the Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt provisions in the Medicaid Program to: 1) expand Medicaid coverage to individuals from age 19 to 65 years old at or below 133 percent of the federal poverty level with a 5 percent income disregard as provided in 42 CFR 435.119; 2) implement a secretary-approved coverage option which incorporates the benefits and services covered under the Medicaid State Plan, including the essential health benefits as provided in §1302(b) of ACA; 3) use the Basic Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program as the state's benchmark benefit package; and 4) establish

provisions for the use of the Supplemental Nutrition Assistance Program (SNAP) option for streamlined enrollment of SNAP recipients who meet eligibility requirements for the new adult group. The department will submit the corresponding SPAs to CMS upon meeting the technical requirements for public notice and undergoing the federally-approved tribal consultation process.

The department hereby proposes to adopt provisions in the Medicaid Program to expand Medicaid coverage to the new adult group, and to establish these provisions in Title 50, Part I of the *Louisiana Administrative Code*. This proposed Rule is also being promulgated to satisfy federal public notice requirements.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 11. Medicaid Expansion under the Affordable Care Act
Chapter 101. Alternative Benefit Plan
§10101. General Provisions

A. Pursuant to the Patient Protection and Affordable Care Act (P.L. No. 111-148), hereafter referred to as the Affordable Care Act (ACA), and §1937 of title XIX of the Social Security Act, the department shall expand Medicaid coverage to individuals from age 19 to 65 years old at or below 133 percent of the federal poverty level with a 5 percent income disregard as provided in 42 CFR 435.119, hereafter referred to as the new adult group.

B. Effective July 1, 2016, the department will expand Medicaid coverage to the new adult group, as defined in §1905(y)(2)(A) of title XIX of the Social Security Act, and provide a secretary-approved coverage option, hereafter referred to as the Alternative Benefit Plan (ABP), which incorporates the benefits and services covered under the Medicaid State Plan, including the essential health benefits as provided in §1302(b) of ACA. The department will utilize a federally-approved benchmark benefit package to ensure that the ABP includes benefits that are appropriate to meet the needs of the new adult group.

1. *Benchmark*—coverage is based on benefits that are at least equivalent to one of the federally statutorily specified benchmark plans.

C. The Basic Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program (FEHBP) will be the benchmark plan used to design the ABP for the state.

D. The ABP shall provide coverage of essential health benefits pursuant to federal regulations in §1302(b) of ACA.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:

§10103. Benefits and Services

A. Minimum Essential Health Benefits. Pursuant to §1302(b) of ACA, the ABP must provide the new adult group with a benchmark benefit or benchmark-equivalent benefit package that includes the required minimum essential health benefits (EHBs) provided in Affordable Insurance Exchanges. There are 10 benefit categories and some of the categories include more than one type of benefit. The following services are considered EHBs:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment:
   a. these services shall be in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive services and chronic disease management; and
10. pediatric services, including oral and vision care.
    a. The requirements of this service category are met through the Early and Periodic Screening, Diagnosis and Treatment Program.

B. Enrollees shall receive the full range of benefits and services covered under the ABP state plan amendment. The ABP package will incorporate the benefits and services covered under the Medicaid State Plan, including the essential health benefits as provided in §1302(b) of ACA.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:

Chapter 103. Supplemental Nutrition Assistance Program Enrollment Option
§10301. General Provisions

A. Effective July 1, 2016, the department may use the Supplemental Nutrition Assistance Program (SNAP) option for streamlined enrollment of SNAP recipients who meet eligibility requirements for the new adult group.

B. In the event the SNAP enrollment option is used, the Medicaid program will not conduct a separate modified adjusted gross income (MAGI) based income determination on SNAP participants. The department will utilize the gross income determination provided by SNAP to make the financial eligibility determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule may have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 by expanding Medicaid coverage to a new targeted adult eligibility group.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule may have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973

by reducing the financial burden for health care costs for certain families who may qualify under the newly eligible adult group.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, March 31, 2016 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Rebekah E. Gee MD, MPH
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Medicaid Expansion under the Affordable Care Act

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is estimated that the implementation of the proposed rule will result in a net state general fund impact of between $37 M in savings and $30 M in costs over the three years reflected in the rule. This net impact includes administrative and program costs, program savings and premium tax revenues. Exclusive of premium tax revenues, it is estimated that the rule will result in a state general fund cost between $53.5 M ($3.8 M Total) and $108.7 M ($4.8 M Total) over the three years reflected in the rule. The range is largely based on a difference in the rate at which eligible individuals enroll in Medicaid and the Per Member Per Month (PMPM) cost per eligible individual. The specific net impact (SGF and Total) itemized below in this rule is based on 463,536 enrolling in Medicaid by FY 19 (of approximately 726,000 projected to be eligible), a cost per eligible individual that does not include supplemental payments (Full Medicaid Payment), a 15 percent reduction in DSH payments, a 3 percent annual growth rate for the PMPM cost, and a significant savings associated with certain current Medicaid recipients whose costs will be eligible for the enhanced federal match rate with expansion. Any changes from the assumptions could result in a material fiscal impact. It is anticipated that the implementation of this proposed rule will result in the following impact on state general funds:

FY 15-16

1. Estimated state general fund administrative costs of $2,999,458;

2. Promulgation costs of $540 ($270 SGF and $270 FED) for this proposed rule and the final rule

Total FY 15-16 cost: $2,999,728

FY 16-17

1. Estimated state general fund administrative costs of $13,976,879;

2. Estimated state general fund programmatic costs of $68,388,574 for Managed Care Organization Payments;

3. Estimated state general fund programmatic savings of $65,956,003 for refinanced programmatic expenditures and DSH payment reductions

Total FY 16-17 cost: $16,409,450

Total FY 16-17 net savings (including premium tax revenues): $9,963,148

FY 17-18

1. Estimated state general fund administrative costs of $14,952,636;

2. Estimated state general fund programmatic costs of $158,692,263 for Managed Care Organization Payments;

3. Estimated state general fund programmatic savings of $139,530,614 for refinanced programmatic expenditures and DSH payment reductions

Total FY 17-18 cost: $34,114,285

Total FY 17-18 net savings (including premium tax revenues): $29,972,176

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in the following impact on revenue collections:

FY 15-16

1. Increase federal revenue collections by approximately $7,318,130 for administrative costs;

2. Increase other revenue collections (provider donations through statutory dedicated funding) by approximately $2,999,458 to fund the required state match for administrative costs;

3. Increase federal revenue collections by approximately $270 for the federal share of promulgation costs for this proposed rule and the final rule

Total FY 15-16 Revenue Collections: $10,317,858

FY 16-17

1. Increase federal revenue collections by approximately $24,793,987 for administrative costs and $1,815,174,258 for programmatic costs;

2. Reduce federal revenue collections by approximately $114,981,077 for refinanced programmatic expenditures and DSH payment reductions

3. Increase other revenue collections (premium tax revenues) by approximately $26,372,598 which will be used to fund the required state match for programmatic and administrative costs;

Total FY 16-17 Revenue Collections: $1,751,359,765

FY 17-18

1. Increase federal revenue collections by approximately $26,387,143 for administrative costs and $2,271,127,904 for programmatic costs;

2. Reduce federal revenue collections by approximately $236,357,740 for refinanced programmatic expenditures and DSH payment reductions

3. Inerease other revenue collections (premium tax revenues) by approximately $64,086,462 which will be used to fund the required state match for programmatic and administrative costs;

Total FY 17-18 Revenue Collections: $2,125,243,769

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule proposes to adopt provisions in the Medicaid Program to expand Medicaid coverage to the new

adult group under the provisions of the Affordable Care Act. It is anticipated that implementation of this proposed rule will increase programmatic expenditures (inclusive of administrative costs) in the Medicaid Program by $10,317,588 in FY 15-16, $1,741,396,617 in FY 16-17 and $2,095,271,593 in FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule may have a positive effect on competition and employment. Medicaid expansion in Louisiana is expected to increase the gross state product which will foster an increase in economic activity, including an increase in revenue for providers and health care partners. The increase in payments may improve the financial standing of providers and could possibly cause an increase in employment opportunities. Medicaid expansion may also potentially increase the competition between managed care organizations and participating providers.

Jen Steele	Evan Brasseaux
Interim Medicaid Director	Staff Director
1602#070	Legislative Fiscal Office

NOTICE OF INTENT

Department of Revenue
Policy Services Division

Public Registry of Motion Picture
Investor Tax Credit Brokers
(LAC 61:III.2701)

Under the authority of R.S. 15:587, R.S. 47:287.785, R.S. 47:295, R.S. 47:1511, and R.S. 47:6007 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue, Policy Services Division, proposes to adopt LAC 61:III.2701.

The primary purpose of this proposed regulation is to create a Public Registry of Motion Picture Investor Tax Credit Brokers as required by Act 451 of the 2015 Regular Session of the Louisiana Legislature.

Title 61
REVENUE AND TAXATION
Part III. Administrative and Miscellaneous Provisions
Chapter 27. Transferable Income and Franchise Tax Credits

§2701. Public Registry of Motion Picture Investor Tax Credit Brokers

A. This Section is applicable to all persons or persons employed by or representing an entity engaged in the sale or brokerage of motion picture investor tax credits which are granted, issued or authorized by the state pursuant to R.S. 47:6007.

B. Definitions

Department—Louisiana Department of Revenue.

Secretary—the Secretary of the Department of Revenue.

Seller or Broker—

a. any person or person employed by or representing an entity engaged in the sale or brokerage of motion picture investor tax credits whose duties include the sale or brokerage of motion picture investor tax credits individually or on behalf of the entity. A seller or broker includes any person or person employed by or representing an entity when the person or entity meets any of the following criteria: The person or entity:

i. holds himself/herself/itself out to be engaged in the business of selling or brokering motion picture investor tax credits; or

ii. has a history of frequent, regular, and repeated sales of motion picture investor tax credits; or

iii. did not purchase the credits at issue for his/her/its own personal use. Any person failing to meet any of the above-mentioned criteria shall be presumed a non-seller or non-broker and thus not subject to the requirements of R.S. 47:6007(C)(7).

b. Further, the entity which earns the motion picture investor credit pursuant to R.S. 47:6007, its affiliates or taxpayer members which receive tax credits via allocation, as verified by department Form R-6135 and R-6140, shall be deemed non-sellers or non-brokers and shall not be subject to the requirements of R.S. 47:6007(C)(7). Every person who meets any of the above-provided requirements shall be subject to the requirements of R.S. 47:6007(C)(7).

C. Initial Registration. Beginning January 1, 2016, all sellers or brokers of motion picture investor tax credits shall apply for the registry and be deemed qualified after meeting the requirements of R.S. 47:6007(C)(aa)-(cc) and undergoing a criminal history background examination by the Louisiana Bureau of Criminal Identification and Information as provided for in R.S. 15:587(A)(1)(h) at the expense of the applicant. Applicants for the registry shall follow the procedure for registration as provided below in Subsection D. However, no seller or broker shall be prevented from transferring motion picture investor tax credits until the effective date of this regulation.

1. Any person deemed qualified to sell or broker motion picture investor tax credit shall be included in the public registry of motion picture investor tax credit brokers, which shall be maintained by the department and made available on its website, www. revenue.la.gov/brokerregistry.

2. No person may sell or broker motion picture investor tax credits on or after the effective date of this regulation without first qualifying for and being included on the public registry of motion picture investor tax credit brokers. All transfers made on or after the effective date of this regulation by a person subject to the requirements of R.S. 47:6007(C)(7) who is not listed on the public registry of motion picture investor tax credits shall be inoperable and of no legal effect and any such transfers shall be deemed ineligible for registration in the Louisiana tax credit registry established pursuant to R.S. 47:1524. Further, failure to so qualify and register with the Department prior to selling or brokering tax credits issued pursuant to R.S. 47:6007 shall be punishable by a fine of not more than $10,000 or imprisonment at hard labor for not more than five years, or both. In addition to the foregoing penalties, a person convicted under the provisions of R.S. 47:6007(C)(7) shall be ordered to make full restitution to any person who has suffered a financial loss as a result of this offense. If a person ordered to make restitution is found to be indigent and therefore unable to make restitution in full at the time of conviction, the court shall order a periodic payment plan consistent with the person's ability to pay.

3. Any person who is determined to no longer be in compliance with the requirements of R.S. 47:6007(C)(7) and