

Section 7 – General Provisions

7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

N/A

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

State/Territory: LOUISIANA

- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [Louisiana] Medicaid state plan, as described below:

To address the COVID-19 public health emergency, the State respectfully requests to modify the tribal consultation process by eliminating the number of notification days before submission of the SPA and/or conducting consultation after submission of the SPA.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).
5. The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

7. Section B – Enrollment

1. The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

To address the COVID-19 public health emergency, the State respectfully requests to modify Hospital Presumptive Eligibility to allow hospitals to make presumptive eligibility decisions for non-MAGI populations.

2. The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

3. The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

State/Territory: LOUISIANA

4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. X The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

The State suspends all cost sharing.

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. X The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

Community Paramedicine: For the duration of the COVID-19 declaration, allow reimbursement for paramedics to treat non-acute incidents on site as “treatment in place” when called onto the scene without transportation to an emergency destination site in order to prevent unnecessary hospitalization and person to person contact during the COVID-19 public health emergency. The following are covered services under the direct supervision of the Medical Director:

- health assessment
- medication compliance
- laboratory specimen collection including but not limited to COVID-19 test
- Hospital discharge follow-up care
- minor medical procedures as approved by the Medical Director
- chronic disease monitoring and education
- assisting patient with accessing telehealth or other services requiring a physician or other licensed practitioner

Provider Qualifications:

A – Certified/licensed by the Bureau of Emergency Medical Services

B – Employed by an ambulance service that is enrolled as a Medicaid provider

C – Have a service scope agreement, based on paramedic’s skills, with the Medical Director of the ambulance service.

Service Limitations: Community Paramedicine services will utilize the physician evaluation and management codes which do not require prior authorization.

The following are non-covered services:

- travel time
- mileage
- services related to hospital-acquired conditions or treatment
- If the recipient has a medical emergency requiring an emergency response, this will be billed under the ambulance medical emergency code
- duplication of services

Interprofessional Assessment and Management Services via Telephone, Audio/Video Platforms, and E-Consults

Effective for dates of service on or after March 19, 2020, Louisiana Medicaid will reimburse interprofessional assessment and management services that occur electronically through electronic health record (EHR) (e-consults), through audio/video platforms, or via telephone.

A qualifying assessment and management service is one in which a member’s treating practitioner requests the opinion and/or treatment advice of a practitioner with a specific specialty or subspecialty different from the requesting practitioner, to assist the treating practitioner in the diagnosis and/or management of the member’s presenting issue.

Provider Qualifications: This policy also applies to services rendered from a member's primary care practitioner to a specialty/subspecialty practitioner. Treating and remote/e-consultant practitioners include the following types: physicians, advanced practice registered nurses, physician assistants, psychologists, and other licensed mental health professionals.

Service Limitations: All e-consults must be conducted through a secure internet exchange between the treating practitioner and the consultant. The system used to complete the e-consult must, as a minimum, comply with the following requirements:

- Be in compliance with current HIPAA and other applicable security and privacy requirements;
- Enable transmission through electronic communication systems to a specialist who uses the information to evaluate the cases for the type of e-consults for which it is used; and
- Be compatible with the primary care or treating provider's electronic health records system.

The purpose of remote interprofessional assessment and management via e-consults, audio/visual platforms, or telephone is to replace a face-to-face evaluation and management (E/M) visits that would be performed by a practitioner with that specialty/subspecialty. E-consult codes for interprofessional assessment and management are not reimbursable if there has been an E/M visit with the specialist/subspecialist during the time period of 14 days prior to or will be an E/M visit 14 days after the remote interprofessional assessment and management occurs (or at the next available appointment date with the specialist if that date is greater than 14 days) if:

- The E/M visit was/is related to the original issue, and
- The E/M visit is with the same specialist/subspecialist (or group) and was completed in addition to the interprofessional assessment and management.

In this circumstance, the e-consult codes shall not be billed for interprofessional assessment and management services when the specialist/subspecialist will bill for an E/M visit.

For the duration of the COVID-19 emergency, when a secure electronic exchange is not available, or the practitioners do not have a compatible electronic health record system, interprofessional assessment and management services may be rendered via audio/visual (telehealth) platforms or telephone. Practitioners must document the reason for using telehealth or telephonic communications.

2. X The agency makes the following adjustments to benefits currently covered in the state plan:

A. To address the COVID-19 public health emergency, the State respectfully requests to expand all prior authorization requirements outlined in detail in the Louisiana State Plan for the duration of the emergency for the following services:

- i. Any medically necessary surgical procedures that require prior authorization either by fee-for-service, managed care, or both.*
- ii. Pediatric Day Health Center (PDHC)*
- iii. physician administered drugs*
- iv. Durable medical equipment (DME)*
- v. Home health services (EHH/PCS)*
- vi. Hospice services*

- vii. Therapies (physical therapy, occupational therapy, speech therapy)*
- B. To address the COVID-19 public health emergency for Long Term Personal Care Services (LT-PCS), 42 CFR 440.167, the State respectfully requests the following adjustments for the duration of the emergency:*
- i. Allow exceptions to the requirements that services must be provided in accordance with the Approved plan of care and supporting documentation;*
 - ii. Allow exceptions to the Personal Care Services Worker qualifications and may allow persons ordinarily prohibited from doing so to serve as direct service workers;*
 - iii. Cease initial assessments for new LT-PCS program applicants;*
 - iv. Allow recipients' re-assessments to go beyond the 18-month requirement. These recipients will continue to be monitored through monthly telephone contacts;*
 - v. Allow exceptions to the requirement that place(s) of service must be documented in the plan of care and the service log;*
 - vi. LT-PCS may be provided in another state without prior approval of the Office of Aging and Adult Services (OAAS) or its designee;*
 - vii. A recipient may receive LT-PCS while living in a home or property owned, operated or controlled by a provider of services who is not related by blood or marriage to the recipient;*
 - viii. The State may increase the maximum number of LT-PCS hours received per week;*
 - ix. The State may allow the personal representative to be the direct service worker; and*
 - x. The State may allow exceptions to the Prior Authorization requirements for the duration of the emergency.*

3. X The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).
4. X Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
- a. X The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
 - b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Telehealth:

5. X The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

State/Territory: LOUISIANA

To address the COVID-19 public health emergency, the State respectfully requests to suspend all face-to-face requirements detailed in the Louisiana State Plan for all services for the duration of the emergency.

Drug Benefit:

6. The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

7. Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

9. The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. Newly added benefits described in Section D are paid using the following methodology:

- a. Published fee schedules –

Effective date (enter date of change): 3/19/2020

Location (list published location): www.lamedicaid.com

- b. Other:

Describe methodology here.

State/Territory: LOUISIANA

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

To address the COVID-19 public health emergency, the State respectfully requests to increase the payment for Nursing Facility leave days from 10 percent of the per diem to 100 percent of the per diem, and include a \$12 increase to the daily per diem rate paid to nursing facilities.

To address the COVID-19 public health emergency, the State respectfully requests to pay Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID) in excess of the 45-day leave of absence days.

To address the COVID-19 public health emergency, the State respectfully requests a hospital rate increase.

- a. Payment increases are targeted based on the following criteria:

- b. Payments are increased through:

- i. A supplemental payment or add-on within applicable upper payment limits:

- ii. An increase to rates as described below.

Uniformly by the following percentage: 10% to 100% of the per diem for hospital leave days

Through a modification to published fee schedules –

Effective date (enter date of change): 1/1/2020

Location (list published location): www.lamedicaid.com

Up to the Medicare payments for equivalent services.

By the following factors:

\$12 per day add-on to the Nursing Facility rate.

State/Territory: LOUISIANA

Payment for services delivered via telehealth:

3. For the duration of the emergency, the state authorizes payments for telehealth services that:
- a. Are not otherwise paid under the Medicaid state plan;
 - b. Differ from payments for the same services when provided face to face;
 - c. Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

- d. Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
- i. Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
 - ii. Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. Other payment changes:

The State respectfully requests approval to exercise the option to pay an enhanced rate for LT-PCS for the duration of the COVID-19 emergency. The state does not currently plan to implement a rate increase for LT-PCS but would like approval should the need come to raise rates to be responsive to COVID-19.

Section F – Post-Eligibility Treatment of Income

1. The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
- a. The individual’s total income
 - b. 300 percent of the SSI federal benefit rate
 - c. Other reasonable amount: _____
2. The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

State/Territory: LOUISIANA

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

To address the COVID-19 public health emergency, the State respectfully requests to delay renewals during the period of the COVID-19 declaration due to the Families First Coronavirus Response Act provisions, and restart renewals, including conducting post eligibility reviews through a phased in approach over the course of six months after COVID-19 declaration ends.

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 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. 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. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.