DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

June 2, 2025

Kimberly Sullivan, J.D.
Medicaid Executive Director
State of Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th Street, Room 769
Baton Rouge, LA 70802

Dear Director Sullivan:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendments (SPA) LA-25-0003 and LA-25-0003-A, submitted on March 7, 2025 and May 6, 2025, respectively, have been approved. The effective date for these SPAs is January 1, 2025.

Through SPA LA-25-0003, Louisiana removes the state's premium lock out period. Through SPA LA-25-0003-A, Louisiana makes corresponding technical edits to its CHIP state plan to demonstrate that the state no longer disenrolls children from coverage due to non-payment of premiums during the continuous eligibility period and no longer implements a premium lock out period.

Your Project Officer is Abbie Walsh. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (667) 290-8863
E-mail: Abagail.Walsh@cms.hhs.gov

If you have additional questions, please contact Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

Sarah deLone
Director

Amendment 30
LA SPA TN 22-0001
CHIP - American Rescue Plan (ARP) Act Coverage
The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.
Effective date: March 11, 2021

Amendment 31
LA SPA TN 23-0042
CHIP – Mandatory Coverage of Age-Appropriate Vaccines
The purpose of this SPA is, in accordance with section 11405 of the Inflation Reduction Act, to cover-age appropriate vaccines approved by the U.S. Food and Drug Administration (FDA) and administered in accordance with recommendations of the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost sharing.
Effective date: October 1, 2023
Implementation date: October 1, 2023

Amendment 32
LA SPA TN 24-0005
CHIP – Continuous Eligibility
The purpose of this SPA is to comply with section 5112 of the Consolidated Appropriations Act (CAA) 2023, which requires states to provide continuous eligibility to children in the Children's Health Insurance Program (CHIP).
Effective Date: January 1, 2024
Implementation date: January 1, 2024

Amendment 33
LA SPA TN 25-0003
CHIP – Premium
The purpose of this SPA is to amend form CS21 to eliminate the premium lock-out period and provide assurance that, in accordance with 42 CFR 457.1130(a)(3), beneficiaries are provided with an opportunity for an impartial review to address disenrollment from the program.
Effective Date: January 1, 2025
Implementation date: January 1, 2025

Amendment 34
LA SPA TN 25-0003-A
CHIP – Premium
The purpose of this SPA is to amend the CHIP State Plan pages to eliminate the premium lock-out period and provide assurance that, in accordance with 42 CFR 457.1130(a)(3), beneficiaries are provided with an opportunity for an impartial review to address disenrollment from the program.
Effective Date: January 1, 2025
Implementation date: January 1, 2025

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

On January 28, 2025, notification of the State's intent to seek approval from CMS to demonstrate compliance with 42 CFR 457.1130(a)(3) by providing assurance that beneficiaries are provided with an opportunity for an impartial review to address disenrollment from the program and to eliminate the premium lock-out period was submitted to the Louisiana Tribes.

TN 25-0003 **Approval Date**: June 2, 2025 **Effective Date**: January 1, 2025

In the event of a state or federally declared disaster or public health emergency, the State may modify the tribal consultation process by shortening the number of days before submission of the SPA and/or conducting consultation after submission of the SPA. The duration of the provisions may not exceed the duration of the state or federal disaster period.

LOUISIANA TITLE XXI STATE PLAN

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes, **with the exception of the from-conception-to-end-of pregnancy population.**
In the event of a FEMA or governor-declared disaster and at the State's discretion, the State may waive cost sharing for families living in FEMA or governor-declared disaster areas at the time of a disaster event.

8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☒ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☒ Premiums:
$50 per month per family where family income is above 212 percent of the federal poverty level (FPL), but no greater than 250 percent of the FPL.

In the event of a FEMA or governor-declared disaster and at the State's discretion, the State may waive or delay collection of premiums at initial application or renewal for families living in FEMA or governor-declared disaster areas at the time of a disaster event. If the State elects to delay collection of premiums, eligible individuals will be enrolled prior to payment of the premium.

8.2.2. ☐ Deductibles:

8.2.3. ☐ Coinsurance or copayments:

8.2.4. ☐ Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42 CFR 457.505(b))

The cost sharing information is explained to potential enrollees through the application, which includes a chart of income eligibility and premium payment amounts. This information is also prominently displayed on the LaCHIP website. If changes are necessary to the cost sharing requirements, all current enrollees are notified by letter of the changes and the effective dates. Public hearings are held to allow the public to comment on any proposed changes to cost sharing.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

8.4.1- MHPAEA ☒ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☒ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☒ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☒ Yes (Specify: Pharmacy co-payments)
☐ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the State does not apply financial requirements on any mental health or substance use disorder benefits, the State meets parity requirements for financial requirements. If the State does apply financial requirements to mental health or substance use disorder benefits, the State must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☒ Yes
☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☒ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the State's methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☒ Yes
☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☒ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of

financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed five percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

Because there will no longer be co-pays, the maximum amount that a family would pay for coverage is $600 per year for premiums. This amount does not exceed five percent of 200 percent FPL.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

All Louisiana Medicaid and SCHIP applications request ethnicity information on each applicant. No cost sharing is imposed on those children who are verified to be a member of a federally recognized tribe. The applicant's statement on the application form is sufficient to exempt the child from any cost-sharing obligations.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

Applicants will not be enrolled in LaCHIP Phase V until they pay for the first month's premium. They will not receive access to benefits and will subsequently be notified that their eligibility is ending due to failure to pay. Coverage may be terminated at the end of the 12-month continuous eligibility period if there are unpaid premiums and it is at least 60 days after the due date. A notice, which provides a 30-day premium grace period, that failure to pay unpaid premiums within the grace period will result in termination of coverage, and the family's right to challenge the proposed termination is sent to the family. If the unpaid premiums are not paid within the 30-day grace period, the family is provided with

a termination notice, which complies with the requirements specified in 42 CFR § 457.340(e). If the premiums are paid after the 30-day grace period, but prior to the end of the 12-month continuous eligibility period, coverage will not be terminated for failure to pay premiums. A new enrollment period and continuous eligibility period will begin, provided the individual is otherwise eligible for CHIP.

In the event of a FEMA or governor-declared disaster and at the State's discretion, the State may waive or delay collection of premiums in accordance with Sections 8.1.1 and 8.2.1.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**

☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The State assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**