

State: **LOUISIANA**

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Citation Condition or Requirement

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1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Louisiana enrolls Medicaid beneficiaries on a Mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)  
1932(a)(1)(B)(ii)  
42 CFR 438.2  
42 CFR 438.6  
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1.  MCO
  - a.  Capitation
  - b.  The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.
2.  PCCM (individual practitioners)
  - a.  Case management fee
  - b.  Other (please explain below)
3.  PCCM entity
  - a.  Case management fee
  - b.  Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
  - c.  Other (please explain below)

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State: **LOUISIANA**

Citation	Condition or Requirement
	<p>If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Provision of intensive telephonic case management</li> <li><input type="checkbox"/> Provision of face-to-face case management</li> <li><input type="checkbox"/> Operation of a nurse triage advice line</li> <li><input type="checkbox"/> Development of enrollee care plans.</li> <li><input type="checkbox"/> Execution of contracts with fee-for-service (FFS) providers in the FFS program</li> <li><input type="checkbox"/> Oversight responsibilities for the activities of FFS providers in the FFS program</li> <li><input type="checkbox"/> Provision of payments to FFS providers on behalf of the State.</li> <li><input type="checkbox"/> Provision of enrollee outreach and education activities.</li> <li><input type="checkbox"/> Operation of a customer service call center.</li> <li><input type="checkbox"/> Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.</li> <li><input type="checkbox"/> Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.</li> <li><input type="checkbox"/> Coordination with behavioral health systems/providers.</li> <li><input type="checkbox"/> Coordination with long-term services and supports systems/providers.</li> <li><input type="checkbox"/> Other (please describe): _____</li> </ul>

42 CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*

If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

**In February 2012, the State incrementally implemented the managed care model as coordinated care networks in three geographic service areas and completed statewide implementation in June 2012.**

A website ([www.MakingMedicaidBetter.com](http://www.MakingMedicaidBetter.com)) was established to keep the public informed during the design of the MCO program and provide current information on progress toward implementation. The website is a “one stop

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State: **LOUISIANA**

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shop” for documents and information regarding MCOs and includes an online form that interested parties can submit electronically to provide suggestions or ask questions.

A MCO Resource Guide for Providers was developed and posted on the website to inform providers of the MCO program and included a program overview, timelines for implementation, how the LDH (formerly DHH) addressed provider concerns, MCO provider recruitment process, information to know about interacting with MCOs, marketing guidelines, etc.

Meetings and presentations were made to legislative committees, advocates such as Covering Kids and Families Coalition, Louisiana Consumer Healthcare Coalition, Louisiana Maternal and Child Health Coalition, Interagency Council on Homelessness, and Office of Developmental Disabilities; associations such as the Louisiana Primary Care Association, Hospital Association, Louisiana Medical Society; health care providers such as physician groups, hospitals, transportation providers and health care plans. Nine public forums were conducted in each of the nine major geographic regions of the state.

An emergency rule creating the managed care model was published in the eight major daily newspapers in Louisiana in September 2010, but was withdrawn to obtain greater public input. After obtaining additional input from stakeholders, the Notice of Intent (NOI) was published on February 20, 2011 in the *Louisiana Register*. LDH solicited written comments and received 24 written comments which were each responded to individually. The public hearing on the Notice of Intent was held on March 30, 2011 with approximately 67 attendees. Feedback received during the administrative rulemaking process was incorporated into both the Request for Proposals issued April 11, 2011 and the Final Rule that was published in the *Louisiana Register* on June 20, 2011. Public input continued during and after the implementation of the program, through website recommendations, public meetings, provider meetings, and LDH Advisory Council meetings, etc.

The final rule and the proposed State Plan amendment were shared with the four federally recognized Tribes in Louisiana (Coushatta, Chitimacha, Biloxi-Tunica, and Jena Band of Choctaws), prior to the submittal of the State Plan Amendment pages to CMS. The Department provided a notification letter to the tribal contacts for each of the four tribes and gave them time to comment on the proposed amendment. The Department continues to utilize every opportunity to engage the tribes, post-implementation, through its CMS-approved tribal notification and comment process.

Outreach and education for Medicaid enrollees who would be enrolled, began in early October 2011 and robust efforts continue to ensure that consumers are abreast of program changes and to provide information on the benefits.

State statute requires a 30-day public comment period for MCO contract amendments and a 45-day public comment period for policy or procedure changes unless LDH finds that imminent peril to the public’s health, safety, or welfare requires immediate approval.

State: **LOUISIANA**

**In addition to LDH’s marketing strategies to raise awareness of managed care, the Medicaid/CHIP outreach infrastructure (eligibility employees throughout the state in concert with community based organizations) will be utilized to provide information and one-on-one assistance.**

**The Louisiana Medicaid Quality Committee meets quarterly and has been a forum for ongoing public involvement. The website [www.MakingMedicaidBetter.com](http://www.MakingMedicaidBetter.com) is continually updated with information about the State’s managed care program and enrollment.**

**Prior to the submission of the State Plan amendment for Bayou Health (now Healthy Louisiana) effective December 1 2015, LDH worked with stakeholders for almost a year seeking input on the design and implementation of the integration of behavioral health services into the Healthy Louisiana MCOs.**

**Public Input Process**

LDH has been committed to a transparent process with stakeholders leading up to integration of behavioral health services into the Healthy Louisiana MCO Model. In November, 2014, LDH announced through a press release plans to integrate all behavioral health services into the existing Healthy Louisiana Medicaid managed care program effective December 1, 2015. Subsequent to the public announcement, LDH held several meetings with the Behavioral Health Advisory Group, which is comprised of over 30 stakeholders, to help develop guidance to assist with the transition of services to the Healthy Louisiana plans. The meetings were held on January 30, 2015, February 20, 2015, March 20, 2015 and April 29, 2015.

In addition to continuing to meet with the advisory group, LDH will continue to utilize the LBHP-Bayou Health Transition Integrated Health Care website as a means to communicate with our stakeholders, including our Healthy Louisiana plans and beneficiaries, of the upcoming Healthy Louisiana changes. LDH maintains a frequently asked questions (FAQs) page on the website to respond to questions LDH has received related to integration. These FAQs are routinely updated as new questions are received. The website location is: <http://new.dhh.louisiana.gov/index.cfm/page/2104/n/434>. LDH published public notice of the waiver changes in newspapers on May 5, 2015.

LDH has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit this State Plan amendment and associated waiver amendments to CMS. This notice was made May 4, 2015.

**D. State Assurances and Compliance with the Statute and Regulations.**

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)  
1903 (m)

1.  The state assures that all of the applicable requirements of section 1903(m) of the Act for MCOs and MCO contracts will be met.

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State: **LOUISIANA**

Citation	Condition or Requirement
42 CFR 438.50(c)(1)	
1932(a)(1)(A)(i)(I) 1905(t)	2. <input type="checkbox"/> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.
42 CFR 438.50(c)(2) 1902(a)(23)(A)	
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A)	4. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
42 CFR 431.51 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	
1932(a)(1)(A)	5. <input checked="" type="checkbox"/> The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A)	6. <input checked="" type="checkbox"/> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
42 CFR 438 1903(m)	
1932(a)(1)(A)	7. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.
42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	
1932(a)(1)(A)	8. <input type="checkbox"/> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
42 CFR 447.362 42 CFR 438.50(c)(6)	
45 CFR 75.326	9. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10. Assurances regarding state monitoring requirements:

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 Transmittal Number: 18-0007

State: **LOUISIANA**

Citation Condition or Requirement

- The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met.
- The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.
- The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

1932(a)(1)(A)  
1932(a)(2)

E. Populations and Geographic Area.

1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E)**, and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

**A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)**  
**1. Family/Adult**

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X				
2. Pregnant Women	§435.116	X				
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X				
4. Former Foster Care Youth (up to age 26)	§435.150	X				
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL )	§435.119	X				
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X				
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X				

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State: **LOUISIANA**

Citation Condition or Requirement

**2. Aged/Blind/Disabled Individuals**

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	X				
9. Aged and Disabled Individuals in 209(b) States	§435.121					N/A
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135	X				
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137	X				
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138	X				
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)( II), and 1905(q) of SSA	X				
14. Disabled Adult Children	1634(c) of SSA	X				

**B. Optional Eligibility Groups**

**1. Family/Adult**

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220					N/A
2. Optional Targeted Low-Income Children	§435.229	X				Unless Chisholm or waiver
3. Independent Foster Care Adolescents Under Age 21	§435.226	X				
4. Individuals Under Age 65 with Income Over 133%	§435.218					N/A
5. Optional Reasonable Classifications of Children Under Age 21	§435.222	X				If not Long Term Care
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA					N/A

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Citation Condition or Requirement

**2. Aged/Blind/Disabled Individuals**

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230					N/A
8. Individuals eligible for Cash except for Institutionalized Status	§435.211	X				
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217		X			
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					N/A
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234					N/A
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236			X		
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA			X		
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii) (VII) and 1905(o) of the SSA	X				
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii) (X) and 1902(m)(1) of the SSA	X				
16. Work Incentive Group	1902(a)(10)(A)(ii) (XIII) of the SSA					N/A
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii) (XV) of the SSA	X				
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii) (XVI) of the SSA					N/A
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii) (XIX) of the SSA	X				
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219	X				

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**3. Partial Benefits**

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214			X		
22. Individuals with Tuberculosis	§435.215	X				
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213	X				

**C. Medically Needy**

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)			X		Spend-down
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)			X		Spend-down
3. Medically Needy Children Age 18 through 20	§435.308			X		Spend-down
4. Medically Needy Parents and Other Caretaker Relatives	§435.310			X		Spend-down
5. Medically Needy Aged	§435.320			X		Spend-down
6. Medically Needy Blind	§435.322			X		Spend-down
7. Medically Needy Disabled	§435.324			X		Spend-down
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330			X		Spend-down

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X		

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State: **LOUISIANA**

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
<b>“Dual Eligibles” not described under Medicare Savings Program</b> - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare			X		
<b>American Indian/Alaskan Native</b> — Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14		X		
<b>Children Receiving SSI who are Under Age 19</b> - Children under 19 years of age who are eligible for SSI under title XVI	§435.120				See mandatory group A-2
<b>Qualified Disabled Children Under Age 19</b> - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA				N/A
<b>Title IV-E Children</b> - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145				Mandatory
<b>Non-Title IV-E Adoption Assistance Under Age 21*</b>	§435.227				Mandatory
<b>Children with Special Health Care Needs</b> - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.					N/A

\* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

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Citation Condition or Requirement

Population	V	E	Notes
<b>Other Insurance</b> --Medicaid beneficiaries who have other health insurance		X	
<b>Reside in Nursing Facility or ICF/IID</b> -- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		X	Individuals residing in nursing facilities and individuals under age 21 residing in ICFs/IID are mandatory enrollees in Healthy Louisiana for specialized behavioral health, applied behavior analysis (ABA)-based therapy and non-emergency ambulance services only.  Skilled nursing facility services may be utilized by members who transition from acute care hospital services as a step-down continuum of care for a specified period of time.
<b>Enrolled in Another Managed Care Program</b> --Medicaid beneficiaries who are enrolled in another Medicaid managed care program			N/A
<b>Eligibility Less Than 3 Months</b> --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program			N/A
<b>Participate in HCBS Waiver</b> --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).	X		
<b>Retroactive Eligibility</b> --Medicaid beneficiaries for the period of retroactive eligibility.			N/A
<b>Other (Please define):</b>			

1932(a)(4)  
 42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
  - a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3). **Information is provided in the member handbook that is available on the State's website, the MCO's website and/or by mail.**

States with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

- b.  If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.

- i. Please indicate the length of the enrollment choice period:  
A minimum of 30 days.

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State: **LOUISIANA**

- c.  If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.
- i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).
  - ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:  
\_\_\_\_\_
2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
- a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).
- Information is provided in the member handbook that is available on the State's website, the MCO's website and/or by mail.**
- b.  If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.
- i. Please indicate the length of the enrollment choice period:  
\_\_\_\_\_
- c.  If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
- i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).  
If the recipient fails to choose an MCO upon application, the State will assign the recipient to a MCO. The automatic assignment methodology shall seek to preserve existing provider-beneficiary relationships during the previous year and relationships with providers that have traditionally served Medicaid beneficiaries. After consideration of provider-beneficiary relationships, the methodology shall assign beneficiaries equitably among MCOs, excluding those subject to the intermediate sanction described in 42 C.F.R. §438.702(a)(4).
- d.  If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.
- i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8)

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State: **LOUISIANA**

1932(a)(4)  
42 CFR 438.54

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

42 CFR 438.52

a.  The state assures that, per the choice requirements in 42 CFR 438.52:

- i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
- ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
- iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

42 CFR 438.52

b.  The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.56(g)

c.  The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.71

d.  The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

1932(a)(4)  
42 CFR 438.56

G. Disenrollment.

- 1. The state will  / will not  limit disenrollment for managed care.
- 2. The disenrollment limitation will apply for 12 months (up to 12 months).
- 3.  The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.
- 4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. (*Examples: state generated correspondence, enrollment packets, etc.*)  
**Medicaid beneficiaries are notified by letter, within two days of approval.**
- 5. Describe any additional circumstances of "cause" for disenrollment (if any).

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Citation Condition or Requirement

H. Information Requirements for Beneficiaries.

1932(a)(5)(c)                       The state assures that its state plan program is in compliance with 42 CFR  
 42 CFR 438.50                      438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity  
 42 CFR 438.10                      programs operated under section 1932(a)(1)(A)(i) state plan amendments.

I. List all benefits for which the MCO is responsible.

1932(a)(5)(D)(b)  
 1903(m)  
 1905(t)(3)

Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state’s Medicaid State Plan. For “other practitioner services”, list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
1. Inpatient hospital services	3.1-A	1-46	1
2. Outpatient hospital services	3.1-A	1-3	2a
3. Ancillary medical services	3.1-A	3	1
4. Organ transplant-related services	3.1-A	3	1
5. Family planning services as specified in 42 CRF 431.51 (b) (2) (not applicable to a MCO operating under a moral and religious objection as specified in the contract)	3.1-A	1	4c
6. EPSDT / well-child visits (excluding dental)	3.1-A	1	4b
7. Emergency medical services	4.19-B	1b (3)	24.a
8. Communicable disease services	3.19-A	1	4c
9. Durable medical equipment and certain supplies	3.1-A	1, 4 and 5	7
10. Prosthetics and orthotics;	3.1-A	1	12c
11. Emergency and non-emergency medical transportation; (ambulance and non-ambulance)	3.1-A	1-4	24a
12. Home health services	3.1-A	1-6	7
13. Basic and Specialized behavioral health services	3.1-A	5-19	13.d
14. School-Based health clinic services provided by LDH Office of Public Health certified school-based health clinics	3.1-A	19	4.b
15. Physician services	3.1-A	1-5	5
16. Maternity services (including nurse midwife services)	3.1-A	1	17, 20a and 20b

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State: **LOUISIANA**

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
17. Chiropractic services	3.1-A	8	4b
18. Rehabilitation therapy services	3.1-A	1 1-2	2a 13d
19. Pharmacy services	3.1-A	1-4	12a
20. Hospice services	3.1-A	1	18
21. Personal care services (Age 0-20)	3.1-A	1	26
22. Pediatric day healthcare services	3.1-A	13-18	4b
23. Audiology services	3.1-A	3	6
24. Ambulatory Surgical Services	3.1-A	2	9
25. Lab and X-ray Services	3.1-A	1	3
26. Emergency and surgical dental services	3.1-A	1	5b
27. Clinic services	3.1-A	1-4	9
28. Pregnancy-related services	3.1-A	1	20a
29. Pediatric and Family Nurse Practitioner services	3.1-A	1	23
30. Licensed mental health professional services	3.1-A	8a 6-7	4b 6
31. FQHC/RHC Services	3.1-A	1-3 1-5	2c 2b
32. ESRD services	3.1-A	1	9
33. Optometrist services	3.1-A	1	5
34. Podiatry services	3.1-A	1	6
35. Rehabilitative services (including Crisis Stabilization)	3.1-A	1-19	13d
36. Respiratory services	3.1-A	40-41	1
37. Applied behavior analysis (ABA)-based therapy services	3.1-A	20	4b
38. Psychiatric Residential Treatment Facility (PRTF) services	3.1-A	1-2	16
39. Skilled nursing facility services for members who transition from acute care hospital services as a step-down continuum of care.	3.1-A	1 1	4a 24d

1932(a)(5)(D)(b)(4) J.  The state assures that each MCO has established an internal grievance and appeal system for enrollees.  
 42 CFR 438.228

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Citation	Condition or Requirement
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1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	K. <u>Services, including capacity, network adequacy, coordination, and continuity.</u>  <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met.  <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met.  <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met.  <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met.  <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
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1932(c)(1)(A)  42 CFR 438.330 42 CFR 438.340	L. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
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1932(c)(2)(A)  42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	M. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
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1932 (a)(1)(A)(ii)	N. <u>Selective Contracting Under a 1932 State Plan Option.</u>  To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.  1. The state will <input checked="" type="checkbox"/> /will not <input type="checkbox"/> intentionally limit the number of entities it contracts under a 1932 state plan option.
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State: **LOUISIANA**

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Citation	Condition or Requirement
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2.  The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.
3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (*Example: a limited number of providers and/or enrollees.*)  
**Contractors were determined through a competitive procurement process. The State's contracted Medicaid fiscal intermediary, its subsidiary companies, parent, or affiliated entities cannot also participate in the Louisiana Medicaid program as a Medicaid provider.**
4.  The selective contracting provision in not applicable to this state plan.

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**Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)**

**States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:**

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. <b>States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.</b>	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. <b>States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.</b>	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
<b>States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.</b>	§ 438.4(b)(9)
<b>States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.</b>	§ 438.66(e)
<b>States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.</b>	§ 438.334
<b>Until July 1, 2018</b> , states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

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Compliance Dates	Sections
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) <b>no later than one year from the issuance of the associated EQR protocol.</b>	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) <b>no earlier than the issuance of the associated EQR protocol.</b>	§ 438.358(c)(6)

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 0938-0933. The time required to complete this information collection is estimated to average 10 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

CMS-10120 (exp. **TBD – currently 4/30/17**)

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