

## Section 7 – General Provisions

### 7.4.1 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
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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.    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),

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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).

- c.  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.

- 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.

**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.
  
- 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.

- 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. \_\_\_\_ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

- 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. \_\_\_ 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):
2. \_\_\_ The agency makes the following adjustments to benefits currently covered in the state plan:

3. \_\_\_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide 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. \_\_\_ 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. \_\_\_ 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. \_\_\_ The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

*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): \_\_\_\_\_
    - Location (list published location): \_\_\_\_\_
  - b.  Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

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

*During the statewide COVID-19 public health emergency (PHE), Louisiana Medicaid will establish an alternative payment methodology (APM) for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to receive reimbursement for COVID-19 monoclonal treatment-only visits at the Medicare rate.*

*Payments under this APM are to cover the additional costs associated with the COVID-19 monoclonal treatment by FQHCs and RHCs during COVID-19 monoclonal treatment visits as the PPS cost base for FQHCs and RHCs did not include these costs.*

*The payments for the monoclonal treatment-only visits provide a needed supplement to FQHCs and RHC reimbursement during this public health emergency.*

*The supplemental amounts made under this APM are in addition to the Prospective Payment System (PPS) rate paid to FQHCs and RHCs for an encounter.*

*The amount in total paid to FQHC and RHC providers is at least their provider-specific PPS rate.*

*Reimbursement will start with dates of services on September 1, 2021, and continue through the end of the federal PHE.*

*Payments made to the FQHCs and RHCs under this APM will be made per submitted claim for a COVID-19 monoclonal treatment-only visit, which will be reimbursed at the Medicare rate.*

*When the COVID-19 monoclonal treatment is administered as part of an otherwise billable FQHC/RHC encounter per Attachment 4.19-B, the encounter is reimbursed under the existing PPS/APM per Attachment 4.19-B; and, no separate reimbursement will be made.*

*FQHC and RHC providers must agree to receive the APM.*

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

*FQHC and RHC providers that administer the COVID-19 treatment when E&M service is not performed.*

*FQHC and RHC providers must agree to the APM to obtain reimbursement for the COVID 19 monoclonal treatment-only visits at the Medicare cost per COVID-19 treatment administration.*

- 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:

Through a modification to published fee schedules –

Effective date (enter date of change): September 27, 2021

Location (list published location): [Louisiana Medicaid COVID-19 Fee Schedules](#)

Up to the Medicare payments for equivalent services.

By the following factors:

*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:

**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.)

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**

#### **PRA Disclosure Statement**

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