ACT 421 IMPLEMENTATION

Stakeholder Work Group

June 29, 2020

MEETING AGENDA & OBJECTIVES

- Review of high-level enrollment process
- Review of prioritization process
- **New Item: Dental Coverage**
- Q & A

Objectives:

- Finalize prioritization structure
- Decision on dental coverage

ACT 421 DEMONSTRATION

Review

ACT 421 DEMONSTRATION FEATURES

- Size of program dependent on legislative appropriation: Number of enrollees tied to legislative appropriation. Program will serve as many children as possible given appropriated budget.
  - Requested approximately $27 million per year ($13.6M for FY2021 with program start in January 2021).
- Enrollees not otherwise qualified for Medicaid
- Initial 5-Year Program
- Prioritization of Hospitalized / Institutionalized Applicants
- Maintenance of Private Insurance: to maximize program resources, families will be required to maintain existing private insurance coverage for enrolled children; hardship exemption will apply. LaHIPP will be available to qualifying families.
- Required managed care enrollment
- Study of cost-sharing in out-years of program for LaHIPP enrollees

TIMELINE

- June 29: Stakeholder work group meeting
- July 7-20: Publication of public notice and start of public comment period
- July 16: Presentation at DD Council meeting
- July 20 – August 11: CMS required public hearings (2 hearings, dates TBD)
- August 21: Presentation at Medicaid Quality Committee
- September 1: Submission to CMS
- September – December: Development and refinement of operational procedures in consultation with stakeholders
- Enrollment, assessment, points of contact between applicants and LGEs
- Level-of-Care (NH & hospital) finalization
- Cost-sharing requirements
- January 1: Requested implementation date (ultimately determined by CMS review timeline)
- RECURRING ACTIVITIES
- September 2020 and continuing as needed through implementation of Act 421: Bi-weekly/monthly stakeholder meetings
- July – January: Weekly/bi-weekly meetings with LGEs, extended beyond January as needed

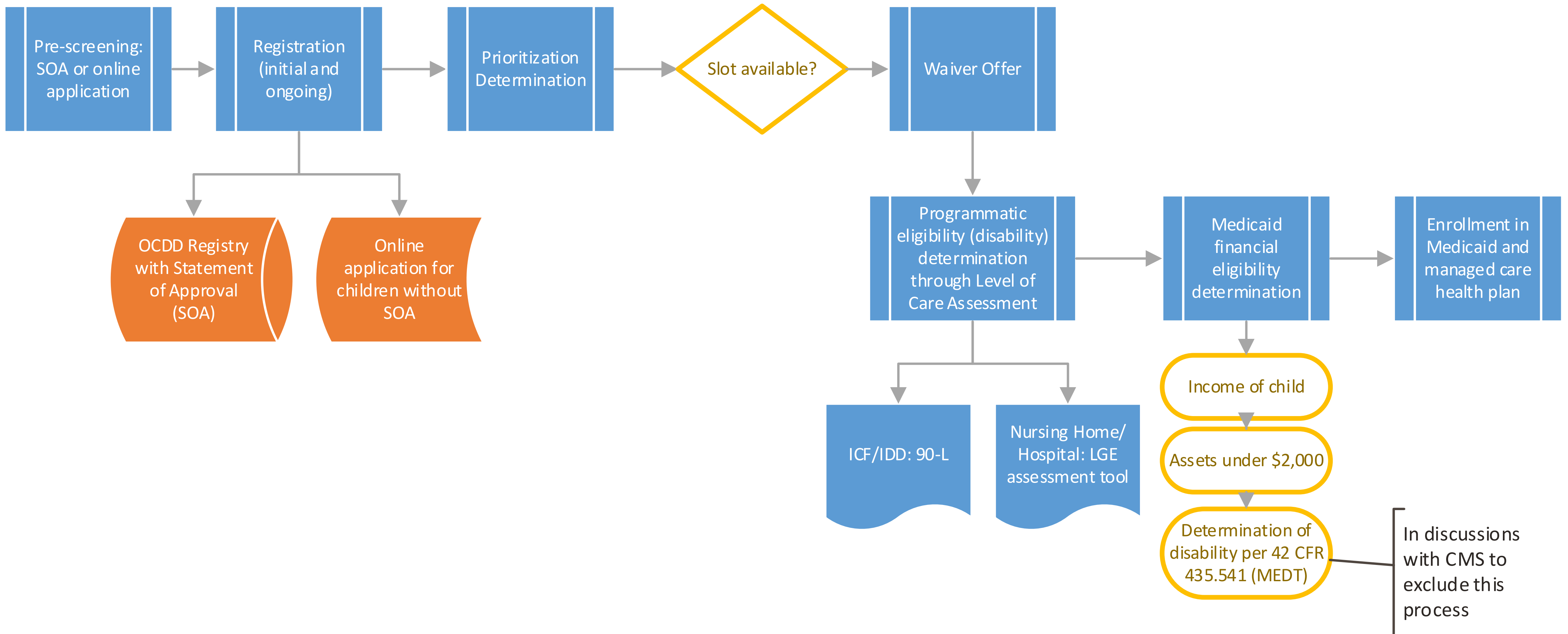
ACT 421 DEMONSTRATION

REGISTRY AND PRIORITIZATION

OVERVIEW

- In order to operationalize registry and enrollment, must determine the following processes:
  - Initial period: How will the program be made available when it is launched?
  - Ongoing period: How will the program be made available following the initial launch?
  - Prioritization: How will children be prioritized for services?
- In today's meeting, we will
  - Review and discuss high-level structure of initial and ongoing registry
  - Review and decide the eligibility criteria for prioritization
- In future meetings, we will
  - Review step-by-step procedures necessary to put initial registry, ongoing registry, and prioritization into practice.

REGISTRATION TO ENROLLMENT OVERVIEW



INITIAL REGISTRY

Initial Period Part 1: Registry of applicants

LDH will create a registry of initial applicants to the Act 421 program, consisting of:

- **Children with SOA not currently receiving Medicaid**: children who are on the OCDD registry and are not currently receiving Medicaid (i.e., do not have a waiver and do not qualify for Medicaid based on income) will be **automatically registered** for Act 421.
- **Children who do not have an SOA:** children who do not currently have an SOA will have one month to register for the Act 421 program.
- LDH will receive input from stakeholders on how to best publicize the Act 421 roll-out to families, as well as using typical methods of notice
- Information relevant to prioritization will be collected

INITIAL REGISTRY

Initial Period Part 2: Randomization of Registry

Applicants will be randomized to create a numerically ordered registry. Randomization will be done without consideration for:

Name of child—list will not be alphabetic, reverse alphabetic

Date/time of registry—all registrations received during the initial registration period will have the same registration date

Method of registration—randomization will not favor applicants receiving automatic registration due to SOA over applicants applying directly for Act 421, or vice versa

INITIAL REGISTRY

Initial Period Part 3: Prioritization

Based on information provided during the registration period, children who qualify will receive prioritization (see later slides), regardless of registry placement.

Children with SOA will receive form to complete allowing them to opt out of the Act 421 registry. If they do not select the opt out option, they will be able to choose a health plan and also request prioritization.

Children without SOA will request prioritization and select a health plan upon application to the Act 421 registry.

If family applies for prioritization on behalf of the child during registration, LDH staff will confirm application meets prioritization requirements using institutional documentation.

If child does not qualify for prioritization, child will be returned to registry pool with original registry number and family will receive notice with appeal rights.

INITIAL REGISTRY

Initial Period Part 4: Enrollment

- Approved prioritized children will receive waiver offers
- Waiver offers will be made to remaining children in numeric order of registry
- After offer received, child will go through Act 421 eligibility process:
  - Level of care assessment through LGE
  - Medicaid financial eligibility for the child with parental disregard
  - Children meeting eligibility requirements will be enrolled in Medicaid and health plan, receive approval notice
  - Children not meeting eligibility requirements will receive denial notice with appeal rights

ONGOING ENROLLMENT AND REGISTRY

- New applicants will receive a registry date and will be placed on the registry in date order (first come, first serve after initial enrollment period).
- New applicants will be eligible for service prioritization.
- As services become available, offers will be made to:

(1) Prioritized children

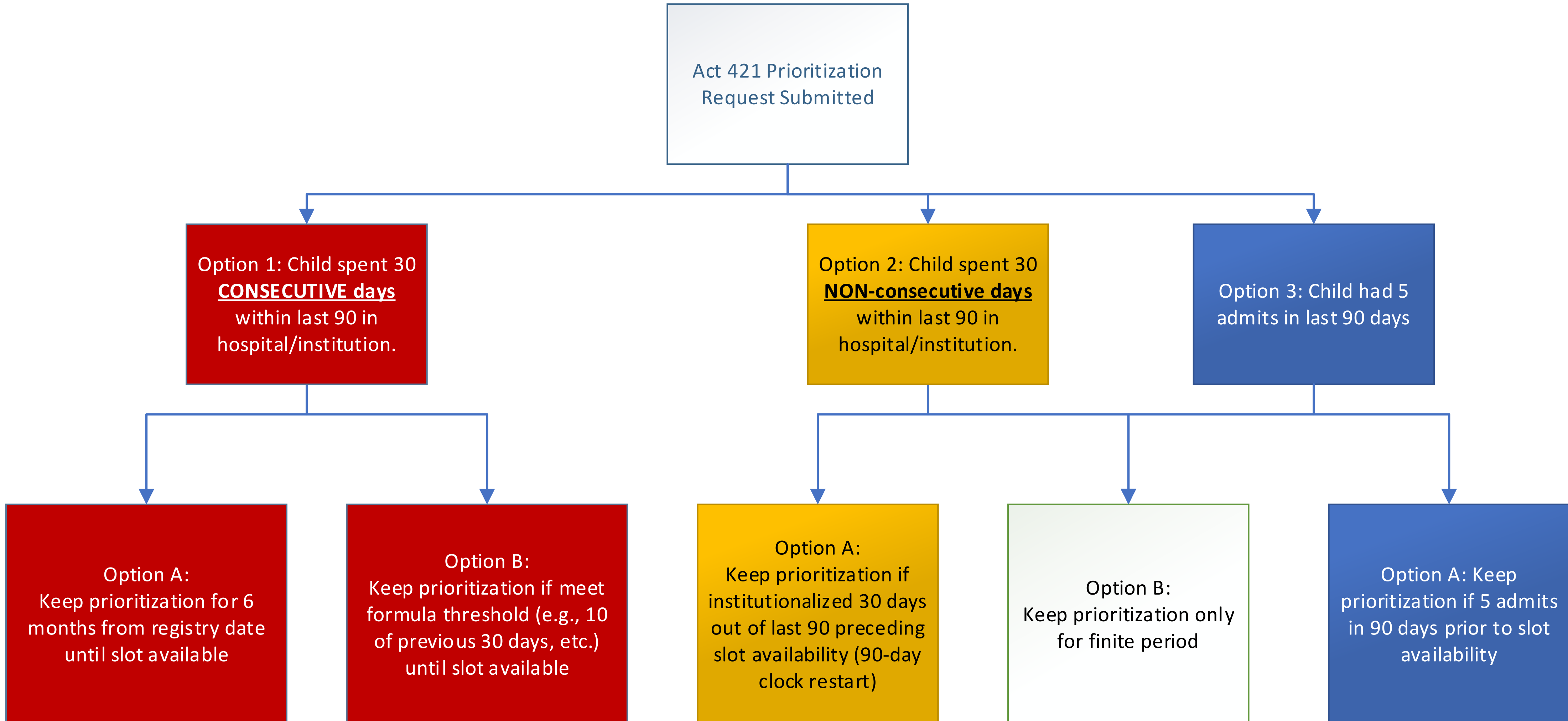
(2) Registry in numeric/date order

- Upon receipt of waiver offer, child will go through Act 421 eligibility determination process:
  - Level of care assessment through LGE
  - Medicaid financial eligibility for the child with parental disregard
  - Children meeting eligibility requirements will be enrolled in Medicaid and health plan, receive approval notice
  - Children not meeting eligibility requirements will receive denial notice with appeal rights

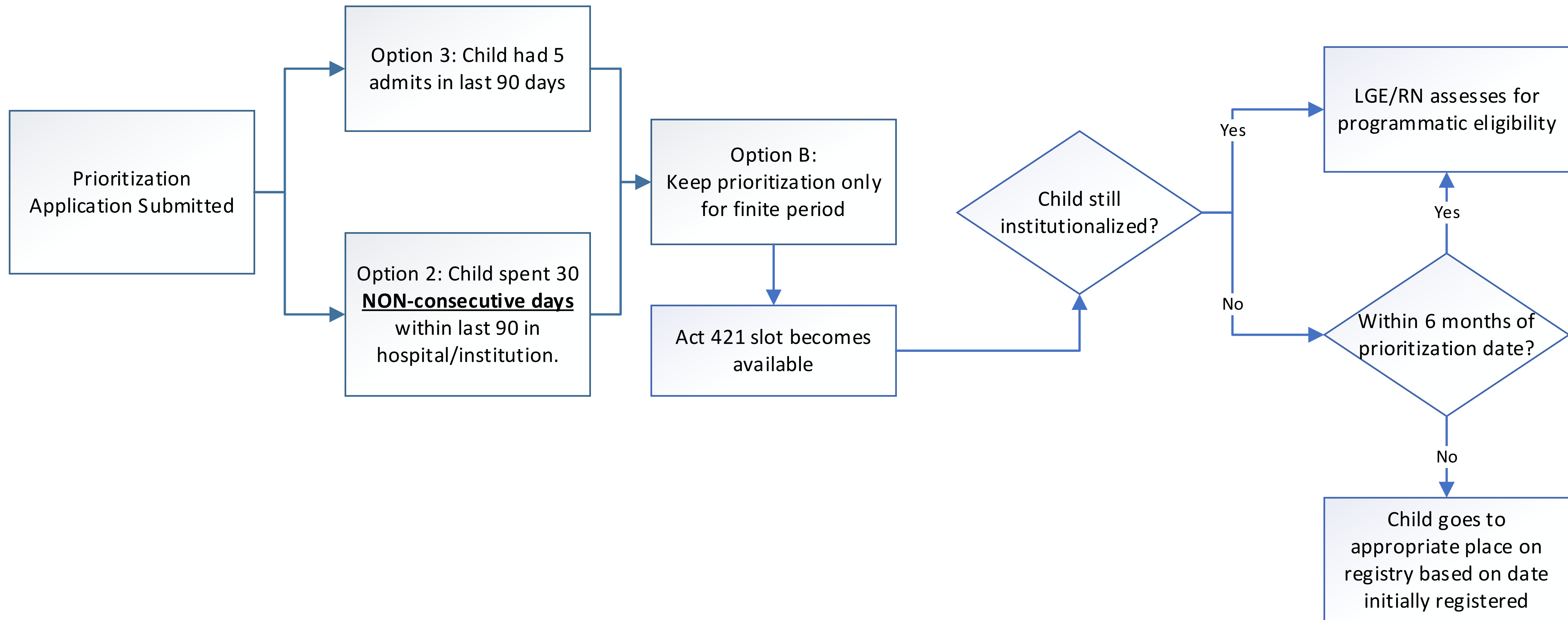
ACT 421 DEMONSTRATION

PRIORITIZATION

ORIGINAL PRIORITIZATION OPTIONS



PRIORITIZATION DECIDED



PRIORITIZATION

Based on the discussion on June 22, LDH will implement the following prioritization protocol.

- Child receives **registry** date corresponding to initial registration for Act 421.
- Prioritization available to child who has:
  - Been hospitalized/institutionalized for 30 of previous 90 days. **Days do not have to be consecutive**.
  - Been admitted to hospital/institution 5 times for inpatient (over 24 hours) in previous 90 days.
- Prioritization is available for finite period of 6 months.
  - For example, a child who is deemed eligible for prioritization on January 1 would receive the next available service offer occurring between January 1 and June 30.
- If more than one prioritized child is awaiting services, the offer is made to the applicant with the earlier **prioritization** date.
- Children who lose prioritization due to the expiration of the 6-month period may re-apply for prioritization; otherwise, offer of services will be made in order of registry placement.
- Families can apply for prioritization at any point prior to receiving services.
- Once a child is enrolled in the Act 421 demonstration, the child maintains enrollment as long as he or she meets Act 421 eligibility criteria and does not need to reestablish meeting prioritization criteria.

PRIORITIZATION – POPULATION ESTIMATE

Prioritized Population

LDH does not have complete estimates as to how many children will qualify for the prioritization.

- Models conservatively assume 10% of eligible population will qualify for prioritization.
- Hospitalization: Data not available. Children eligible due to hospitalization are not tracked currently since hospitalization alone does not meet criteria for eligibility and there can be many causes for hospital stays for children that do not qualify as a disability under Act 421.
- Nursing Home: Average of 8 children in nursing homes in 2020
- ICF: There are currently 66 children in ICFs
  - Note: If child in ICF, they likely need higher level of service such as offered in an HCBS waiver, rather than having needs met by Act 421 option.

ACT 421 DEMONSTRATION: DENTAL COVERAGE OPTION

NEW DECISION - DENTAL

- Should the Act 421 program cover dental coverage?
  - Dental was not originally included in slot estimations
    - Actuaries were still finalizing rate-setting for the dental program now that it is moving forward with two dental benefit program managers—preliminary rates were completed this week.
    - It reduces non-dental service availability when primary stakeholder request has been to expand coverage to as many enrollees as possible.
  - LDH can request an exclusion of dental services from Act 421 coverage.
    - To date, there has been no expressed interest in dental services, so we would like stakeholder feedback on priorities for this population.
    - CMS permission required since it is an EPSDT state plan service.
    - We would consult CMS on dental exclusion prior to submission.
  - If dental included, the per-member, per-month cost would be approximately $22.69 per month.

ESTIMATED ANNUAL ENROLLMENT: WITH AND WITHOUT DENTAL

Managed Care with Private Insurance	Average Per Member Annual Cost	Max of Slot Range*
Physical/BH only	$10,293.54	2,589
With Dental	$10,538.59	2,540
Difference (1.8%)	$245.05	(49)
*Slot range dependent on progression of administrative costs with LGEs for LOC assessments, implementation pace, attrition, etc.		

NAME SURVEY

https://www.surveymonkey.com/r/27K3WFX

- Act 421 Medicaid Access Demonstration (AMAD)
- Children’s Medicaid Equity Waiver (C-MEW)
- Louisiana Medicaid Access Waiver (LaMAW)
- Medicaid Access for Children with Disabilities (MACD)
- Act 421 Children’s Medicaid Option (421-CMO)
- Other?

ACT 421 DEMONSTRATION: QUESTIONS/CONCERNS/MISCELLANEOUS

APPENDIX

TEFRA in other states

TEFRA AROUND THE COUNTRY

- 21 states offer TEFRA or a TEFRA-like program; 1 additional state has a pending application with CMS to implement through an 1115 demonstration
  - 16 states offer TEFRA as a state plan option: Alaska, Delaware, D.C., Georgia, Idaho, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, Oklahoma, South Carolina, South Dakota, West Virginia, Wisconsin
  - 4 states offer TEFRA through the 1115 comprehensive waiver under which all Medicaid services are provided: Delaware, New Hampshire, Rhode Island, Vermont. In these states, TEFRA operates much like a state plan option.
  - 1 state operates a TEFRA-like 1115 program: Arkansas
  - 1 state has a pending application for a TEFRA-like 1115 program: Tennessee
  - 1 additional state (New Jersey) offers managed long-term services and supports to children who meet nursing home level of care

TEFRA-LIKE 1115: ARKANSAS

- No enrollment cap
- Enrollees have access to all medically necessary state plan services
- Cost-Sharing
  - Monthly premium assessed on a sliding scale for families whose income is at least $25,001 and exceeds 150% of federal poverty limit
  - Lowest premiums, family income $25,001-$50,000: 1% of income, $20-$41 per month
  - Highest premiums, family income $200,001 and up: 2.75%, capped at $458 per month
- Insurance
  - Children can be enrolled in TEFRA and other health insurance coverage.
  - Families who voluntarily drop health coverage after enrolling in TEFRA are ineligible for Medicaid benefits for 6 months after the health insurance coverage is dropped.

TEFRA-LIKE 1115: TENNESSEE APPLICATION

- Tennessee offers all services under a managed care 1115 waiver.
- Submitted a “Katie Beckett” amendment on 9/20/19 – has not yet received CMS approval
- Budget for Katie Beckett programs dependent on legislative appropriation
- Includes HCBS wraparound services for some children
- Cost-Sharing
  - Monthly premium assessed on families whose modified adjusted gross income (MAGI) exceeds 150% of federal poverty limit for some families
    - MAGI assesses household income in context of household size
- Insurance
  - Some families required to maintain employer-sponsored insurance, with hardship exception
  - HIPP available
- Note: Tennessee has not expanded Medicaid.

TERMINOLOGY CONFUSION

Katie Beckett Option vs. Katie Beckett Waiver

- Katie Beckett was the girl whose circumstances prompted the change in the law that created TEFRA and disregard of parental income for children on 1915(c) waivers.
- Not a legally defined term
- Katie Beckett option usually refers to a state plan option.
- Katie Beckett waiver is any 1915(c) home-and-community-based waiver that disregards parental income.
  - All states have Katie Beckett waivers.
  - Children's Choice, NOW, and ROW are Katie Beckett waivers

Medicaid Deeming Waiver

- TEFRA programs are sometimes referred to as "deeming waivers."
- Refers to Medicaid provision that "deems" parental income to a child, thus excluding the child from Medicaid. TEFRA allows for disregard of parental income, thus waiving the deeming provision under Medicaid.

1915(c) Waiver vs. 1115 Demonstration Waiver

- Demonstration "Waiver" does not have the meaning normally associated with Medicaid services for people with disabilities.
- There are no home and community-based services offered.