**NOTICE OF INTENT**

**Department of Health**
**Bureau of Health Services Financing**

**Dental Benefits Prepaid Ambulatory Health Plan**
**(LAC 50:1.Chapter 21)**

The Department of Health, Bureau of Health Services Financing proposes to amend LAC 50:I.Chapter 21 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing the dental benefits prepaid ambulatory health plan in order to allow for more than one dental benefits plan manager to service Medicaid enrollees and to allow for the department to contract with a vendor for enrollment broker services for member enrollment into one of the available plans.

**Title 50**

**PUBLIC HEALTH – MEDICAL ASSISTANCE**
**Part 1. Administration**
**Subpart 3. Managed Care for Physical and Behavioral Health**

**Chapter 21. Dental Benefits Prepaid Ambulatory Health Plan**

**§2101. General Provisions**

A. Effective May 1, 2014, the Department of Health, Bureau of Health Services Financing shall adopt provisions to establish a comprehensive system of delivery for dental services covered under the Medicaid Program. The dental benefits plan shall be administered under the authority of a 1915(b) waiver by implementing a prepaid ambulatory health plan (PAHP) which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. All Medicaid recipients except those residing in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) that are receiving dental services through the fee-for-service system will receive dental services administered by a dental benefit plan manager (DBPM).

1. The number of DBPMs shall be no more than required to meet the Medicaid enrollee capacity requirements and ensure choice for Medicaid recipients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:784 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 46:

**§2103. Participation Requirements**

A. ...

B. A DBPM must:

1. -5. ...

6. be without an actual or perceived conflict of interest that would interfere or give the appearance of impropriety or of interfering with the contractual duties and obligations under this contract or any other contract with LDH, and any and all applicable LDH written policies. Conflict of interest shall include, but is not limited to, the contractor serving, as the Medicaid fiscal intermediary contractor for LDH;

7. be awarded a contract with LDH, and successfully completed the readiness review prior to the start date of operations; and

B.8. – I.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:784 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 46:

**§2105. Prepaid Ambulatory Health Plan Responsibilities**

A. – A.1. ...

2. A DBPM shall possess the expertise and resources to ensure the delivery of dental benefits and services to

members and to assist in the coordination of covered dental services, as specified in the terms of the contract.

3. A DBPM shall have written policies and procedures governing its operation as specified in the contract and department issued guidance.

4. A DBPM shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status or need for dental services, and shall not use any policy or practice that has the effect of discriminating on any such basis.

5. The DBPM shall abide by all enrollment and disenrollment policy and procedures as outlined in the contract developed by the department.

B. The department will contract with an enrollment broker who will be responsible for the enrollment and disenrollment process for DBPM participants. The enrollment broker shall be:

1. the primary contact for enrollees regarding the DBPM enrollment and disenrollment process, and shall assist the recipient to enroll in a DBPM;

2. the only authorized entity, other than the department, to assist an enrollee recipient in the selection of a DBPM; and

3. responsible for notifying all DBPM members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in the contract.

C. Enrollment Period. The annual enrollment of a DBPM member shall be for a period of up to 12 months from the date of enrollment, contingent upon his/her continued Medicaid eligibility. A member shall remain enrolled in the DBPM until:

1. LDH or its enrollment broker approves the member's written, electronic or oral request to disenroll or transfer to another DBPM for cause; or

2. the annual open enrollment period or after the lock-in period; or

3. the member becomes ineligible for Medicaid and/or the DBPM program.

D. Automatic Assignment Process

1. LDH shall establish an auto-assignment process for potential enrollees who do not request enrollment in a specified DBPM, or who cannot be enrolled into the requested DBPM for reasons including, but not limited to, the DBPM having reached its enrollment capacity limit or as a result of LDH-initiated sanctions.

2. DBPM automatic assignments shall take into consideration factors including, but not limited to:

a. assigning members of family units to the same DBPM. If multiple DBPM linkages exist within the household, the enrollee shall be enrolled to the DBPM of the youngest household enrollee;

b. existing provider-enrollee relationships; or

c. previous DBPM-enrollee relationship.

3. Auto-assignments on any basis other than household enrollment in DBPM will not be made to a DBPM whose enrollee share is at or above 60 percent of the total statewide membership.

E. Voluntary Selection of DBPM for New Enrollees

1. Potential enrollees shall be given an opportunity to choose a DBPM at the time of application. Once the potential enrollee is determined eligible, their choice of DBPM shall be transmitted to the enrollment broker.

2. During the 90 days following the date of the enrollee's initial enrollment into a DBPM, the enrollee shall be allowed to request disenrollment without cause by submitting an oral or written request to the enrollment broker.

3. All eligible enrollees shall be provided an annual open enrollment period at least once every 12 months thereafter.

4. All enrollees shall be given the opportunity to choose a DBPM at the start of a new DBPM contract either through

the regularly scheduled open enrollment period or special enrollment period.

F. Annual Open Enrollment

1. The department will provide an opportunity for all DBPM members to retain or select a new DBPM during an annual open enrollment period. The enrollment broker will mail a re-enrollment offer prior to each annual enrollment period to the DBPM member. Each DBPM member shall receive information and the offer of assistance with making informed choices about the participating DBPMs and the availability of choice counseling.

2. The enrollment broker shall provide the individual with information on each DBPM from which they may select.

3. During the open enrollment period, each Medicaid enrollee shall be given 60 calendar days to either remain in their existing DBPM or select a new DBPM.

G. Selection or Automatic Assignment of a Primary Dental Provider for Mandatory Populations for All Covered Services

1. The DBPM is responsible to develop a primary dental provider (PDP) automatic assignment methodology in accordance with the department's requirements for the assignment of a PDP to an enrollee who:

a. does not make a PDP selection within 30 calendar days of enrollment to the DBPM;

c. selects a PDP within the DBPM that has reached their maximum physician/patient ratio; or

d. selects a PDP within the DBPM that has restrictions/limitations (e.g., pediatric only practice).

2. Assignment shall be made to a PDP with whom the enrollee has a provider-beneficiary relationship. If there is no provider-beneficiary relationship, the enrollee may be auto-assigned to a provider who is the assigned PDP for a household family member enrolled in the DBPM. If other household family members do not have an assigned PDP, auto-assignment shall be made to a provider with whom a family member has a provider-beneficiary relationship.

3. If there is no enrollee or household family provider-beneficiary relationship, enrollees shall be auto-assigned to a PDP, based on criteria such as age, geographic proximity, and spoken languages.

4. An enrollee shall be allowed to request at any time, verbally or in writing, to change his or her PDP and the DBPM must agree to grant the request.

H. Disenrollment and Change of Dental Benefit Plan Manager

1. An enrollee may request disenrollment from the DBPM as follows:

a. for cause, at any time. The following circumstances are cause for disenrollment:

i. the DBPM does not, because of moral or religious objections, cover the service the enrollee seeks;

ii. the enrollee needs related services to be performed at the same time; not all related services are available within the DBPM and the enrollee's PDP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

iii. the contract between the DBPM and LDH is terminated;

iv. poor quality of care rendered by the DBPM as determined by LDH;

v. lack of access to DBPM covered services as determined by LDH; or

vi. any other reason deemed to be valid by LDH and/or its agent; or

b. without cause for the following reasons:

i. During the ninety 90 days following the date of the beneficiary's initial enrollment into the DBPM or during the 90 days following the date the enrollment broker sends the beneficiary notice of that enrollment, whichever is later;

ii. upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual open enrollment opportunity;

iii. when LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3); or

iv. after LDH notifies the DBPM that it intends to terminate the contract as provided by 42 CFR §438.722.

I. Involuntary Disenrollment

1. The DBPM may request involuntary disenrollment of an enrollee if the enrollee's utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee's ID card to another person to obtain services. In such case the DBPM shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).

2. The DBPM shall submit disenrollment requests to the enrollment broker, in a format and manner to be determined by LDH.

3. The DBPM shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

4. The DBPM shall not request disenrollment because of an adverse change in physical or mental health status or

because of the enrollee's health diagnosis, utilization of medical services, diminished mental capacity, preexisting medical condition, refusal of medical care or diagnostic testing, attempt to exercise his/her rights under the DBPM's grievance system, or attempt to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. Further, in accordance with 42 CFR §438.56, the DBPM shall not request disenrollment because of an enrollee's uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment seriously impairs the DBPM's ability to furnish services to either this particular enrollee or other enrollees.

5. The DBPM shall not request disenrollment for reasons other than those stated in the contract with LDH. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the DBPM is not requesting disenrollment for other reasons by reviewing and rendering decisions on all disenrollment request forms submitted to the enrollment broker.

6. All disenrollment requests shall be reviewed on a case-by-case basis and the final decision is at the sole discretion of LDH or its designee. All decisions are final and not subject to the dispute resolution process by the DBPM.

7. When the DBPM's request for involuntary disenrollment is approved by LDH, the DBPM shall notify the

enrollee in writing of the requested disenrollment. The notice shall include:

a. the reason for the disenrollment;

b. the effective date;

c. an instruction that the enrollee choose a new DBPM; and

d. a statement that if the enrollee disagrees with the decision to disenroll, the enrollee has a right to submit a request for a state fair hearing.

8. Until the enrollee is disenrolled by the enrollment broker, the DBPM shall continue to be responsible for the provision of all DBPM covered services to the enrollee.

J. A DBPM shall be required to provide service authorization, referrals, coordination, and/or assistance in scheduling the covered dental services as specified in the terms of the contract.

1. – 2. Repealed.

K. The DBPM shall establish and implement a quality assessment and performance improvement program as specified in the terms of the contract and department issued guidance.

L. A DBPM shall develop and maintain a utilization management program including policies and procedures with defined structures and processes as specified in the terms of the contract and department issued guides.

M. The DBPM must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The DBPM shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid programs as well all requirements set forth in the contract and department issued guidance.

1. – 1b. Repealed.

N. A DBPM shall collect data on enrollees and provider characteristics and on services furnished to members through an encounter data system as specified in the contract and all department issued guidance.

1. – 8. Repealed.

O. A DBPM shall be responsible for conducting routine provider monitoring to ensure:

1. continued access to dental care for eligible Medicaid recipients; and

2. compliance with departmental and contract requirements.

3. – 16. Repealed.

P. A DBPM shall not engage the services of a provider who is in non-payment status with the department or is excluded from participation in federal health care programs (i.e., Medicare, Medicaid, CHIP, etc.).

1. – 2. Repealed.

Q. Dental records shall be maintained in accordance with the terms and conditions of the contract. These records shall be safeguarded in such a manner as to protect confidentiality and avoid inappropriate disclosure according to federal and state law.

R. The DBPM shall provide both member and provider services in accordance with the terms of the contract and department issued guides.

1. The DBPM shall submit provider manuals and provider directory to the department for approval prior to distribution, annually and subsequent to any revisions.

a. The DBPM must provide a minimum of 60 days' notice to the department of any proposed material changes to the member handbooks and/or provider manuals.

b. After approval has been received from the department, the DBPM must provide a minimum of 30 days' notice to the members and/or providers of any proposed material changes to the required member education materials and/or provider manuals.

S. Member education materials shall include, but not be limited to:

1. a welcome packet including, but not limited to:

a. a welcome letter highlighting major program features and contact information for the DBPM; and

b. a provider directory when specifically requested by the member (also must be available in searchable format on-line);

2. member rights and protections as specified in 42 CFR §438.100 and the DBPM's contract with the department including, but not limited to:

a. a member's right to change providers within the DBPM;

b. any restrictions on the member's freedom of choice among DBPM providers; and

c. a member's right to refuse to undergo any dental service, diagnoses, or treatment or to accept any service provided by the DBPM if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;

3. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the DBPM or the department including, but not limited to reporting to the department's Medicaid Customer Service Unit if the member has or obtains another health insurance policy, including employer sponsored insurance; and

4. the amount, duration, and scope of benefits available under the DBPM's contract with the department in

sufficient detail to ensure that members understand the benefits to which they are entitled, including, but not limited to:

a. information about oral health education and promotion programs;

b. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;

c. how members may obtain benefits, including emergency services, from out-of-network providers;

d. the policy on referrals for specialty care; and

e. the extent to which, and how, after-hour services are provided;

5. information to call the Medicaid Customer Service Unit toll-free telephone number or visit a local Medicaid eligibility office to report changes in parish of residence, mailing address or family size changes;

6. a description of the DBPM's member services and the toll-free telephone number, fax telephone number, e-mail address and mailing address to contact DBPM's member services department;

7. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English, Spanish and Vietnamese; and

8. grievance, appeal and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and in the DBPM's contract with the department.

T. The provider manual shall include but not be limited to:

1. description of the DBPM;

2. core dental benefits and services the DBPM must provide;

3. emergency dental service responsibilities;

4. policies and procedures that cover the provider complaint system. This information shall include, but not be limited to:

a. specific instructions regarding how to contact the DBPM to file a provider complaint; and

b. which individual(s) has the authority to review a provider complaint;

5. information about the DBPM's grievance system, that the provider may file a grievance or appeal on behalf of the member with the member's written consent, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;

6. medical necessity standards as defined by LDH and practice guidelines;

7. practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

8. primary care dentist responsibilities;

9. other provider responsibilities under the subcontract with the DBPM;

10. prior authorization and referral procedures;

11. dental records standards;

12. claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;

13. DBPM prompt pay requirements;

14. notice that provider complaints regarding claims payment shall be sent to the DBPM;

15. quality performance requirements; and

16. provider rights and responsibilities.

U. The provider directory for members shall be developed in two formats:

1. a hard copy directory for members and, upon request, potential members; and

2. a web-based online directory for members and the public.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:784 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR:

**§2109. Benefits and Services**

A. – D. ...

E. Utilization Management

1. The DBPM shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review and service authorization, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The DBPM shall submit an electronic copy of the UM policies and procedures to LDH for written approval within thirty calendar days from the date the contract is signed by the DBPM, but no later than prior to the readiness review, annually thereafter, and prior to any revisions.

2. – 10. ...

11. The DBPM shall submit written policies and processes for LDH approval, within thirty calendar days, but no later than prior to the readiness review, of the contract signed by the DBPM, on how the core dental benefits and services the DBPM provides ensure:

11.a. – 17. ...

18. The DBPM shall report fraud and abuse information identified through the UM program to LDH's Program Integrity Unit.

19. – 19.g. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:786 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR:

**Family Impact Statement**

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 as it is expected have a positive effect as the availability of multiple plans will provide families with a greater choice of available providers and services.

**Poverty Impact Statement**

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed

Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 as it is expected have a positive effect as the availability of multiple plans will provide families with a greater choice of available providers and services.

**Small Business Analysis**

In compliance with Act 820 of the 2008 Regular Session of the Louisiana Legislature, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule will have a no impact on small businesses, as described in R.S. 49:965.2 et seq.

**Provider Impact Statement**

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

**Public Comments**

Interested persons may submit written comments to Ruth Johnson, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030. Ms. Johnson is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is at 4:30 p.m. on July 30, 2020.

Interested persons may submit a written request to conduct a public hearing by U.S. mail to the Office of the Secretary ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629; however, such request must be received no later than 4:30 p.m. on July 10, 2020. If the criteria set forth in R.S. 49:953(A)(2)(a) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on July 30, 2020 in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after July 10, 2020. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing. In the event of a hearing, parking is available to the public in the Galvez Parking Garage, which is located between North Sixth and North Fifth/North and Main Streets (cater-corner from the Bienville Building). Validated parking for the Galvez

Garage may be available to public hearing attendees when the parking ticket is presented to LDH staff at the hearing.

Dr. Courtney N. Phillips

Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES**

**RULE TITLE: Dental Benefits Prepaid Ambulatory Health Plan**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state programmatic costs of approximately $1,242 for FY 19-20, $3,126,849 for FY 20-21 and $2,307,825 for FY 21-22. It is anticipated that $2,484 ($1,242 SGF and $1,242 FED) will be expended in FY 19-20 for the state's administrative expense for promulgation of this proposed rule and the final rule. In addition, if the state contracts with more than one dental benefit management plan, this is expected to increase current administrative costs of the program.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed Rule will increase federal revenue collections by approximately $1,242 for FY 19-20, $3,126,849 for FY 20-21 and $2,307,825 for

FY 21-22. It is anticipated that $1,242 will be collected in FY 19-20 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NON-GOVERNMENTAL GROUPS (Summary)

This proposed rule amends the provisions governing the dental benefits prepaid ambulatory health plan in order to allow for more than one dental benefits plan manager to service Medicaid enrollees and to allow for the department to contract with a vendor for enrollment broker services for member enrollment into one of the available plans. This proposed Rule will be beneficial to recipients by increasing the availability of plans, which will provide families with a greater choice of available providers and services as it will allow for multiple dental benefits plan managers. It is anticipated that implementation of this proposed rule will result in programmatic costs to the Medicaid program of $6,253,698 in FY 20-21 and $4,615,650 in FY 21-22. In addition, if the state contracts with more than one dental benefit management plan, this is expected to increase current administrative costs of the program

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule may have a positive effect on competition and employment, as it will increase the number of dental benefits plan managers.