LA SPA 25-0025

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Enrollment Broker (LAC 50:I.3105 and 3107)

The Department of Health, Bureau of Health Services Financing proposes to amend LAC 50:I.3105 and 3107 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 managed care organizations (MCOs) to simplify the enrollment process. The proposed Rule updates language by removing parts that are no longer relevant, removes the annual enrollment period, and allows beneficiaries to change which MCO they are enrolled with twice in a calendar year. This will provide beneficiaries with more freedom of choice regarding their MCO plan.

The Rule text below has been drafted utilizing plain language principles to ensure clarity and accessibility for all users. It has also been reviewed and tested for compliance with web accessibility standards.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health
Chapter 31. General Provisions
§3105. Enrollment Process

A. …

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

1. the primary contact for Medicaid beneficiaries regarding the MCO enrollment and disenrollment process, and shall assist the beneficiary with MCO enrollment;

2. the only authorized entity, other than the department, to assist a Medicaid beneficiary in the selection of an MCO; and

3. …

C. Enrollment Period. The enrollment of an MCO member shall be based on a calendar year, contingent upon his/her continued Medicaid eligibility. A member shall remain enrolled in the MCO until:

1. the member submits a request to transfer to another MCO. The member may request to transfer to another MCO without cause up to two times per calendar year. After transferring a second time, the member will remain in that MCO until the end of the calendar year unless the member submits a for cause disenrollment request that is approved; or

2. Repealed.

3. …

D. - D.4.Repealed.

E. Special Enrollment Provisions for Mandatory, Opt-In Population Only

1. Mandatory, opt-in populations may request participation in Healthy Louisiana for physical health services at any time. The effective date of enrollment shall be no later than the first day of the second month following the calendar month the request for enrollment is received. Retroactive begin dates are not allowed.

2. …

3. Following an opt-in for physical health and selection of an MCO and subsequent 90-day choice period, these members may transfer to another MCO up to two times for the remainder of the calendar year. If the member transfers a second time, the member will be locked in that MCO until the beginning of the next calendar year unless they elect to disenroll from physical health, or the member submits a for cause disenrollment request that is approved.

F. Enrollment of Newborns. Newborns of Medicaid eligible mothers, who are enrolled at the time of the newborn's birth, will be automatically enrolled with the mother's MCO.

1. If there is an administrative delay in enrolling the newborn and costs are incurred during that period, the member shall be held harmless for those costs and the MCO shall pay for those services.

2. - 2.b.…

G. Selection of an MCO

1. As part of the eligibility determination process, Medicaid and LaCHIP applicants, for whom the department determines eligibility, shall receive information and assistance with making informed choices about participating MCOs from the enrollment broker. These individuals will be afforded the opportunity to indicate the MCO of their choice on their Medicaid application or in a subsequent contact with the department prior to determination of Medicaid eligibility.

2. All new beneficiaries who have made a proactive selection of an MCO shall have that MCO choice transmitted to the enrollment broker immediately upon determination of Medicaid or LaCHIP eligibility. The member will be assigned to the MCO of their choosing unless the MCO is otherwise restricted by the department.

a. Beneficiaries who fail to choose an MCO shall be automatically assigned to an MCO by the enrollment broker, and the MCO shall be responsible to assign the member to a primary care provider (PCP) if a PCP is not selected at the time of enrollment into the MCO.

b. For mandatory populations for all covered services as well as mandatory, specialized behavioral health populations, the auto-assignment will automatically enroll members using a hierarchy that takes into account family/household member enrollment, or a round robin method that maximizes preservation of existing provider-enrollee relationships.

3. All new beneficiaries shall be immediately, automatically assigned to an MCO by the enrollment broker if they did not select an MCO during the eligibility determination process.

a. Repealed.

4. All new beneficiaries will be given 90 days to change MCOs if they so choose.

a. Repealed.

5. The following provisions will be applicable for beneficiaries who are mandatory participants.

a. …

b. Enrollees may request to transfer out of the MCO for cause and the effective date of enrollment into the new plan shall be no later than the first day of the second month following the calendar month that the request for disenrollment is filed.

H. Automatic Assignment Process

1. The following participants shall be automatically assigned to an MCO by the enrollment broker in accordance with the department's algorithm/formula and the provisions of §3105.D:

a. mandatory MCO participants;

b. …

c. other beneficiaries as determined by the department.

2. - 2.e.…

3. MCO assignment methodology shall be available to enrollees upon request to the enrollment broker.

I. Selection or Automatic Assignment of a Primary Care Provider for Mandatory Populations for All Covered Services

1. - 2. …

3. If the enrollee does not select an MCO and is automatically assigned to a PCP by the MCO, the MCO shall allow the enrollee to change PCP, at least once, during the first 90 days from the date of assignment to the PCP.

4. …

J. Enrollment Period

1. Members have 90 days from the initial date of enrollment into an MCO in which they may change the MCO for any reason. Beginning on the ninety-first day, the member will be able to change his/her MCO for any reason up to two times for the remainder of the calendar year. If the member transfers two times, he/she will remain in his/her MCO until the end of the calendar year, unless disenrolled under one of the conditions described in this Section, with the exception of the mandatory, opt-in populations, who may disenroll from Healthy Louisiana for physical health and return to legacy

Medicaid at any time. Beginning January first of the following calendar year, the member will again be able to change MCOs up to two times per calendar year.

K. - K.3. Repealed.

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 37:1574 (June 2011), amended LR 40:310 (February 2014), LR 40:1097 (June 2014), LR 41:929 (May 2015), LR 41:2364 (November 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 42:755 (May 2016), LR 52:

§3107. Disenrollment and Change of Managed Care Organization

A. A member may request disenrollment from an MCO for cause once the member has changed MCOs two times in a calendar year.

B. A member may request disenrollment from an MCO without cause at the following times:

1. …

2. at any time, up to two times per calendar year. After the second transfer, the enrollee will remain in that MCO for the remainder of the calendar year unless they receive approval for a for cause disenrollment;

3. upon automatic re-enrollment; or

B.4. - C.4. ...

D. Disenrollment for Cause

1. A member may initiate disenrollment or transfer from their assigned MCO after the first 90 days of enrollment for cause once the member has changed MCOs two times in a calendar year. The following circumstances are cause for disenrollment:

D.1.a. - G.2. ...

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 37:1575 (June 2011), amended LR 40:311 (February 2014), LR 41:931 (May 2015), LR 41:2365 (November 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 52:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

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 may have a positive impact on family functioning, stability and autonomy as described in R.S. 49:972 since it will allow beneficiaries to have more freedom of choice in their MCO.

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 no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Small Business Analysis

In compliance with the Small Business Protection Act, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule will have no impact on small businesses.

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 Tangela Womack, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. Ms. Womack is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is December 22, 2025.

Public Hearing

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 December 10, 2025. If the criteria set forth in R.S. 49:961(B)(1) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on December 29, 2025, in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after December 10, 2025. 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.

Bruce D. Greenstein
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Managed Care for Physical and Behavioral Health—Enrollment Broker

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

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 25-26. It is anticipated that $1,349 ($675 SGF and $674 FED) will be expended in FY 25-26 for the state's administrative expense for promulgation of this proposed rule and the final rule.

This proposed rule amends the provisions governing enrollment in managed care organizations (MCOs) to update language, remove the open enrollment period, and ease transfer restrictions by allowing beneficiaries to change what MCO they are enrolled in twice a year. After the second transfer, beneficiaries will be required to remain with their selected MCO for the remainder of the calendar year unless they submit a for-cause disenrollment request that is approved by the department.

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

It is anticipated that the implementation of this proposed rule will have no effect on state or local governmental revenue collections for FY 25-26. It is anticipated that $674 will be collected in FY 25-26 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 NONGOVERNMENTAL GROUPS (Summary)

This proposed rule amends the provisions governing enrollment in managed care organizations (MCOs) to update language, remove the open enrollment period, and ease transfer restrictions by allowing beneficiaries to change what MCO they are enrolled in twice a year. This will provide beneficiaries with more freedom of choice regarding their MCO plan. It is anticipated that implementation of this proposed rule will not result in costs to providers in FY 25-26, FY 26-27, FY 27-28. The rule may result in some shifts in enrollment between MCOs, but each MCO will continue to receive the appropriate per-member per-month payments based on actual enrollment. Therefore, the rule is not anticipated to result in a net fiscal impact to MCOs.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

LDH does not anticipate any significant impact on competition or employment among DBPMs, as the rule maintains equitable access to beneficiaries and does not alter provider network requirements or payment structures.

Drew Maranto	Alan M. Boxberger
Interim Medicaid Executive Director	Legislative Fiscal Officer
2511#048	Legislative Fiscal Office