LOUISIANA DEPARTMENT OF HEALTH

Louisiana Medicaid Coverage Decision Process Update

The Center for Evidence-based Policy

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Executive Summary

In 2018, Louisiana Department of Health (LDH) leadership identified the need to update its process for making medical, behavioral health, and dental coverage decisions for fee-for-service (FFS) Medicaid and Medicaid managed care. LDH leadership determined a need for more clear, effective, and evidence-informed processes and policies to enable Louisiana Medicaid to better serve enrollees and the citizens of Louisiana, particularly in a context of limited resources. In September 2018, LDH contracted with the Center for Evidence-based Policy (Center), based at Oregon Health & Science University (OHSU), to assist in the development of an updated framework and process for medical, behavioral health, and dental coverage decisions.

To identify potential process updates for LDH's consideration, the Center used a 2-step procedure to identify and synthesize best practices, internal and external stakeholder needs, and shared principles for coverage decision-making processes. The Center's approach included a policy scan of 5 states and an online statewide survey.

The Center and LDH synthesized the information to inform a proposed framework and process updates for determining coverage of medical, behavioral health, and dental services. Information from the policy scan, along with survey data, were used to identify the following potential components of an updated framework and process for coverage decisions:

Benefit Identification

Identifying potential medical, behavioral health, and dental benefits for coverage consideration is an important first step in the coverage decision process. There are various mechanisms for identifying potential benefits such as the use of data and horizon scanning, stakeholder recommendations, state legislative and federal directives, and newly released and updated billing codes. Although Louisiana Medicaid currently uses an online benefit consideration request process, agency leadership have an opportunity to improve the benefit identification process by making the online submission portal more easily accessible and clearly communicating key decision process components to stakeholders. Louisiana Medicaid leadership could choose to require submission of supporting research, and they could establish standards for evidence review. Enhanced communication and use of a standardized process to collect and evaluate evidence can increase transparency and create greater opportunities for stakeholder participation in identifying important benefits for consideration. Requiring the submission of supporting research with benefit consideration requests can help Louisiana Medicaid be more responsive to the changing health care environment.

Benefit Selection & Prioritization

After potential medical, behavioral health, or dental benefits have been identified, it is important that only benefits that are relevant to the needs of Louisiana Medicaid enrollees are selected for further review. It is also critical that benefits are ordered by priority to ensure that the most important benefits are reviewed first. Louisiana Medicaid leadership could consider using consistent and transparent criteria to select benefits for further review and developing criteria to prioritize the order in which benefits are reviewed. These process changes can increase the transparency of the coverage decision-making process, and reduce the time needed for the benefit review process.

Evidence Review

After benefits have been prioritized for further evaluation, it is standard practice among the state Medicaid agencies we reviewed to undertake a careful study of evidence to ensure informed coverage decisions. Louisiana Medicaid should develop a core set of high-quality sources for identifying evidence to use in the coverage decision process. Louisiana Medicaid leadership could consider using an evidence grading system, or other standardized processes, to guide the review of research and to ensure the prioritization of high-quality evidence in the evaluation of benefits. Using consistent, high-quality sources for evidence will ensure that Louisiana Medicaid's coverage decisions are evidence-based and up-to-date. In addition, having clear, well-documented processes for evidence review can increase transparency and stakeholders' trust that coverage decisions are based on up-to-date information and the best possible research.

Policy Development

In addition to a review of evidence, the state Medicaid agencies we interviewed also consider clinical practice guidelines, other payers' benefit coverage, and fiscal, regulatory, and other implementation considerations when determining whether a medical, behavioral health, or dental service is covered. Medicaid agency staff take all of these factors into consideration when drafting policy language and establishing coverage criteria. In the states we reviewed, Medicaid policy development staff have established internal policy decision processes, work collaboratively with fiscal, data, and legal departments, adhere to a state's rule making process (as applicable), and collaborate with other state agencies and stakeholders to work through implementation considerations.

Post-Implementation Utilization Review

After a coverage policy has been implemented, some state Medicaid agencies periodically review utilization data to understand the general use of a new or revised benefit, and to identify any residual implementation issues such as billing inconsistencies, provider discrepancies, or general fiscal implications.

Communication

Clear communication is an important factor in engaging stakeholders that should be considered as an underlying component of the updated Louisiana Medicaid coverage decision process. Louisiana Medicaid leadership should consider establishing defined communication points along the benefit identification, evidence review, and policy development timeline at which stakeholders are updated on the progress of the benefit under review. LDH leadership should also clearly communicate the outcome of the coverage decision process once a decision has been made.

As LDH leadership continue to determine how these proposed framework and process updates will be implemented, they might identify additional components or alternative mechanisms for addressing key focus areas, as guided by the shared principles that were identified in the stakeholder survey. For each of the components of the updated framework, identifying and managing potential conflict of interest will be essential for supporting an equitable and transparent coverage decision process. At the time of this report, the LDH was vetting potential process updates, and therefore specific details about the next phases of the project are not included in this summary.

Introduction

In 2018, LDH leadership identified the need to update the process for determining medical, behavioral health, and dental coverage decisions for fee-for-service (FFS) Medicaid and Medicaid managed care. LDH leadership determined a need for more clear, effective, and evidence-informed processes and policies that enable Louisiana Medicaid to better serve enrollees and the citizens of Louisiana, particularly in a context of limited resources. In September 2018, LDH contracted with the Center, based at OHSU, to assist in the development of an updated framework and process for medical, behavioral health, and dental coverage decisions.

To create a transparent system that balances covered services and available resources, LDH recognized the need to continually evaluate covered services, develop a well-defined coverage decision-making process, and engage stakeholders at key points throughout the process. The Center designed an approach to help LDH leadership accomplish this goal: 1) identifying best practices in state Medicaid coverage decision processes, 2) identifying stakeholder needs, and 3) identifying important principles to guide coverage decision-making processes. Information from these project components is being used to design updates to the framework and process for determining coverage of medical, behavioral health, and dental services and to develop tools to facilitate a transparent and evidence-based coverage decision process.

Project Approach

The Center worked with LDH leadership to determine the goals of this multiphase project (Figure 1). This report discusses the findings of Phase I of the project. Subsequent project phases will gather and incorporate stakeholder feedback on the proposed framework and process updates (Phase II), and develop tools and conduct LDH staff training to support the implementation of new framework and process updates (Phase III). The following report sections discuss the goals, methods, process, and findings from Phase I of this project.

State Scan

The Center conducted a scan of state Medicaid programs to identify core elements of state Medicaid coverage decision processes. The scan included a review of processes in 5 states.

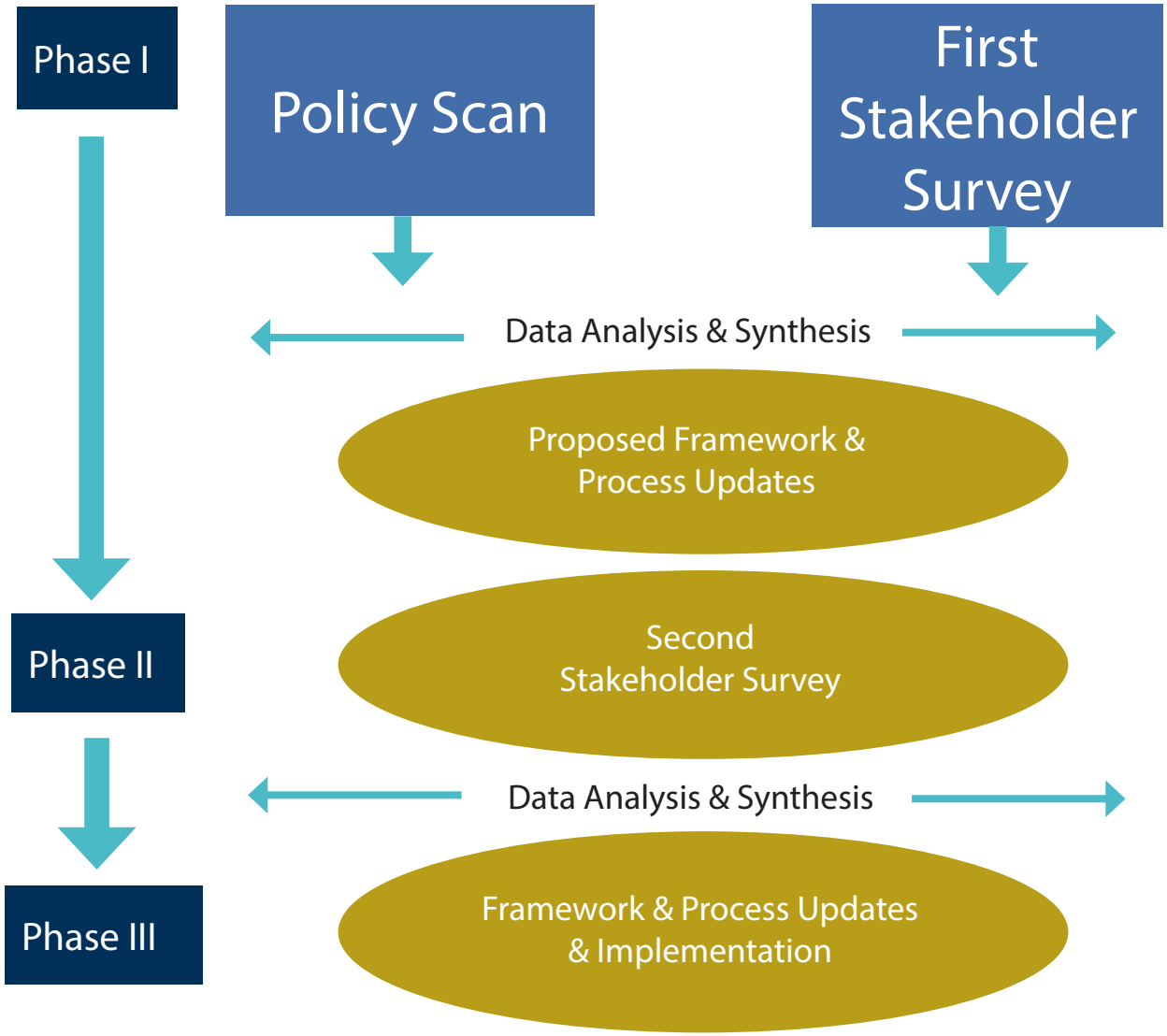
Stakeholder Survey

The Center used an online survey to gather a broad range of stakeholder perspectives related to the strengths of the current medical, behavioral health, and dental services coverage decision process, opportunities for improvement, and core principles for consideration.

Proposed Framework and Process Updates

The Center and LDH synthesized the information from the policy scan and stakeholder survey to create proposed updates to the framework and process for making medical, behavioral health, and dental service coverage decisions.

FIGURE 1: PROJECT APPROACH



Policy Scan

Overview

The Center conducted a policy scan to identify core elements of state Medicaid coverage decision processes. The scan included a review of coverage decision processes in 5 states – Alabama, Florida, Oklahoma, Tennessee, and Texas – and focused on key features and best practices in the following areas:

- Coverage decision processes
- Stakeholder engagement strategies
- Relationships with managed care

Table 1 includes an overview of the Medicaid population size, primary delivery system, and number of managed care plans in each state reviewed.

Methods

The Center and LDH selected states to include in the review based on similarities to the Louisiana Medicaid program, such as the number of enrollees served, regional proximity, and use of different care delivery models (FFS, managed care). Among the 5 Medicaid programs reviewed, program sizes range from 783,000 enrollees (Oklahoma) to over 4 million enrollees (Florida, Texas). Although Louisiana Medicaid delivers services primarily through a managed care arrangement, a small portion of the Louisiana Medicaid population is covered through FFS. Thus, 3 of the 5 programs reviewed are predominately managed care, with 6% or less of their populations covered by FFS Medicaid. Among these states, FFS coverage is generally provided for specific eligibility categories (e.g., newly eligible individuals, American Indian), for enrollees with certain health conditions (e.g., children with special health care needs), or for benefit categories carved out from managed care (e.g., family planning). Two Medicaid programs included in the review predominately use FFS with a primary care case management

TABLE 1: OVERVIEW OF STATES INCLUDED IN POLICY SCAN

State	Medicaid Population	Primary Delivery System (% of Covered Population)	Number of Comprehensive Managed Care Plans
Alabama	909,000	Primary care case management/ Fee-for-service	n/a
Florida	4.2 million	Managed care (92%)	17 plans
Louisiana	1.5 million	Managed care (91%)	5 plans
Oklahoma	783,000	Primary care case management/ Fee-for-service	n/a
Tennessee	1.4 million	Managed care (100%)	4 plans
Texas	4.3 million	Managed care (94%)	19 plans

Abbreviations. n/a: not applicable. Source: Kaiser Family Foundation. Total monthly Medicaid and CHIP enrollment. 2018; https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed 10/30/2018

model (Alabama, Oklahoma). The policy scan focused on 3 areas:

- *Coverage decision process*: including benefit identification and selection processes, key policy review components, policy development processes, and post-implementation review process
- *Stakeholder engagement strategies*: including methods for engaging stakeholders, opportunities and timing for input, and communications
- *State relationships with Medicaid managed care contractors*: focusing on state expectations for alignment of managed care and FFS coverage criteria and engagement of managed care plans in the coverage decision process

Center researchers reviewed written policies and procedures for each Medicaid program. In addition, Center researchers conducted semi-structured interviews with state Medicaid medical directors and other senior policy and program staff involved with medical, behavioral health, and dental coverage decisions. A standard interview guide was developed with a focus on state processes for determining and communicating coverage decisions (see Appendix A). Before each interview, a list of key discussion areas and a brief description of the project were emailed to participants. Interviews were conducted by telephone with 1 to 4 individuals in each state, and ranged from 45 to 60 minutes in length. A list of state interviewees is in Appendix B.

Findings

Across the 5 state Medicaid programs reviewed, each program presented a unique approach and process for determining coverage of medical, behavioral health, and dental services. Yet, there are multiple similarities in state Medicaid approaches to coverage decision processes. Common practices among the programs reviewed are discussed below.

Coverage Decision Processes

A main focus of this review was state Medicaid approaches to core components within the coverage decision process, including benefit identification and selection, evidence review, policy development processes, and post-implementation utilization review. For each of the components discussed below, identifying and managing potential conflict of interest is essential for supporting an equitable and transparent coverage decision process.

Benefit Identification & Selection

Medicaid programs face significant demand to update coverage policies; review new services, technologies, and procedures; and respond to stakeholder requests for coverage of medical, behavioral health, and dental services. Benefits for review are identified through multiple sources, such as the following:

- State legislative direction
- New billing codes released by the Centers for Medicare and Medicaid Services (CMS)
- Federal mandates
- Internal agency leadership
- External stakeholder requests

In addition to responding for requests to review, some state Medicaid agencies use retrospective processes, such as reviewing provider complaints or appeals requests, to identify important benefits for consideration. State Medicaid programs also proactively use utilization review of claims data to identify benefit use trends or potential coverage issues.

Some Medicaid programs have also created explicit and standardized processes for external stakeholders to request a review of a benefit for coverage. Three of the Medicaid programs reviewed use formal processes to solicit benefits for consideration from stakeholders (Alabama, Florida, Texas). Alabama Medicaid uses a dossier process for stakeholders to submit topics for consideration (see Box A).[1] Florida Medicaid requires that all requests for coverage are submitted to a specific email address and provides guidance on the type of information to include in a topic coverage request submission.[2] Texas Medicaid requires that stakeholders submit a standard benefit nomination form that includes relevant information on the requested service, technology, or procedure.[3] All 3 states require that submitters provide any relevant research to support the request for coverage.

State Medicaid programs all have the challenge of addressing a large volume of requests for review, and work to prioritize topics based on agency priorities and topic urgency. Some Medicaid agencies have developed criteria to guide the selection and prioritization of topic reviews; other Medicaid programs use more general categories, such as the potential that a service might be lifesaving, to prioritize the review of topics. In general, topics that have the potential to be effective, safe, and cost-effective are prioritized over topics that could have questionable efficacy, safety, and cost implications.

BOX A: Alabama Medicaid Dossier Process

Alabama Medicaid has an established dossier process for stakeholders to submit topics to be considered for coverage.[1] The dossier process requires the submitter to provide evidence supporting the effectiveness, safety, and cost-effectiveness of the proposed new benefit and its potential to increase the net health outcome of Alabama Medicaid enrollees. Dossier submitters are required to classify the types of evidence submitted (e.g., systematic review, randomized controlled trial, expert opinion), and provide any unpublished studies. The dossier submission worksheet also requires the submitter to list any applicable codes and a summary of other payer coverage policies.

Evidence Review

The use of a standardized evidence review process establishes an information base to guide coverage decisions. State Medicaid programs use key questions about the effectiveness of services, comparisons to alternatives, the balance of harms versus benefits, costs, the strength of evidence for specific outcomes, how other payers have approached coverage determinations, and recommendations from professional societies to guide the topic review.

All of the Medicaid programs we reviewed draw on high-quality[A], core sources for evidence review. For example, evidence sources include vendors such as Hayes, Inc. and health technology reviews by the Agency for Healthcare Research and Quality or the National Institute for Health and Care Excellence in the United Kingdom. Some state Medicaid programs have developed explicit expectations for the standards of evidence needed to support coverage determinations. Tennessee has established a hierarchy of evidence (see Box B), defined in administrative rule and incorporated into TennCare's (Tennessee Medicaid) definition of medical necessity, which is used to evaluate the quality of evidence on a topic.[4] TennCare's medical necessity definition requires a specific level of evidence in order to allow coverage for a service, product, or procedure. The rule establishes that all benefit requests will be classified

[A] High-quality sources produce independent research, do not accept industry funding, and have established processes in place to mitigate and address any potential influences from conflict of interest.

as having a supporting evidence level of A, B, C, or D.[4] The evidence levels are defined by the type of supporting evidence available. For example, level A evidence is defined as Type I evidence, or multiple Type II evidence, or combinations of Type II, III, or IV evidence with consistent results. TennCare rules state that level A evidence cannot be based on Type III, IV or V evidence alone. Services that are supported by A or B levels of evidence are considered safe and effective if risks are not greater than equally effective alternatives; services with a C level of evidence will be considered safe and effective only if the provider can demonstrate that the service is the optimal intervention for the enrollee's specific condition or treatment needs; services with a D level of evidence are not considered safe and effective. Services are considered "not experimental or investigational" if they are safe and effective.

Florida Medicaid also uses administrative rule to establish the expectation for using a review of evidence, clinical practice guidelines, other payer policies, and utilization trends in the coverage determination process (see Box C).[5] Definitions of terminology used as part of the topic nomination process (e.g., reliable evidence, medical necessity) are also defined in Florida Medicaid's Policy.[6]

Some Medicaid programs participate in multistate collaboratives that support the research and development of evidence-based coverage decisions, such as the Medicaid Evidence-based Decisions (MED) Project. MED is a self-governing, multistate collaborative of 20 states that produces evidence and policy reviews on topics selected by participating states. MED is convened and staffed by the Center, and Louisiana is a participating state. Three of the 5 state Medicaid programs reviewed participate in MED (Alabama, Tennessee, and Texas).

Policy Development

In addition to an evidence review, all of the Medicaid programs included in this report include a review of Medicare coverage, national private payers, and other state Medicaid program coverage to inform policy development. For clinical practice guidelines, state Medicaid program staff commonly review position statements and clinical practice guidelines from professional associations. In addition, state Medicaid staff scan federal and state requirements and resources from the Food and Drug Administration, as applicable.

BOX B: TennCare Evidence Hierarchy

(1200-13-16-.01)

HIERARCHY OF EVIDENCE shall mean a ranking of the weight given to medical evidence depending on objective indicators of its validity and reliability including the nature of and source of the medical evidence, the empirical characteristics of the studies or trials upon which the medical evidence is based, and the consistency of the outcome with comparable studies. The hierarchy in descending order, with Type I given the greatest weight is:

- Type I: meta-analysis done with multiple, well-designed controlled clinical trials
- Type II: one or more well-designed experimental studies
- Type III: well-designed, quasi-experimental studies
- Type IV: well-designed, non-experimental studies
- Type V: other medical evidence defined as evidence based
  - Clinical guidelines, standards, or recommendations from respected medical organizations or governmental health agencies
  - Analyses from independent health technology assessment organizations
  - Policies of other health plans

As part of the coverage decision process, state Medicaid programs identify potential implementation issues as critical factors to consider. After state Medicaid staff have reviewed evidence and clinical guidelines, they work to identify implementation considerations as early as possible in policy development. This happens through direct communication and collaboration with other units and departments (e.g., fiscal, legal, rate-setting, prior authorization and utilization review, managed care, and claims administration departments).

Decision-Making Processes & Review Bodies

All of the state Medicaid programs reviewed have established internal coverage policy decision processes. In some Medicaid programs, the Medicaid medical director makes the final decision on coverage determinations; other states use a broader approach that includes approval from other department leads such as fiscal, quality, and/or regulatory units. All state Medicaid staff members interviewed noted that the scope and complexity of a topic influences the decision-making process. For example, services that have a greater fiscal impact might require executive leadership review, such as the Medicaid Director, or in some cases, the governor. In addition, some state Medicaid programs use external advisory committees such as the federally-required Medical Care Advisory Committee as an avenue to receive feedback and solicit stakeholder comments on draft policies.

Some state Medicaid programs rely on established medical necessity criteria to guide coverage determinations. TennCare's medical necessity criteria, for example, requires that in addition to a service or product being effective and safe and not investigational or experimental, it must also be the least costly alternative course of diagnosis or treatment for an enrollee's condition (see Box D).[4] Florida Medicaid uses a similar set of criteria and refers to its topic nomination and evidence review process (Generally Accepted Professional Medical Standards) as a key component for determining medical necessity (see Box E).

Box C: Florida Medicaid – Determining Medical Standards (59G-1.035)

To determine whether the health service is consistent with generally accepted medical standards, the Agency shall consider the following factors:

1.. Evidence-based clinical practice guidelines

2. Published reports and articles in the authoritative medical and scientific literature related to the health service (published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations)

3. Effectiveness of the health services in improving the individual's prognosis or health outcomes

4. Utilization trends

5. Coverage policies by other creditable insurance payer sources

6. Recommendations or assessments by clinical or technical experts on the subject or field

Communication Strategies

State Medicaid programs use a range of strategies to communicate with and gather input from external stakeholders during the coverage decision process. The following are examples of such broad and targeted engagement strategies:

Broad Engagement Strategies

- *Benefit nominations*: As described above, 3 of the state Medicaid programs reviewed use standard processes to solicit topics for consideration from stakeholders. Alabama Medicaid uses a dossier process; Florida and Texas Medicaid programs have dedicated benefit nomination processes and submission criteria.

- *Stakeholder communication*: Websites and listservs allow for consistent communication across stakeholder groups and the opportunity to communicate about key decisions along the policy development process continuum. State Medicaid programs with more formal benefit nomination processes also provide communication and policy development status updates directly to a submitter. Some state Medicaid programs, such as Florida and Oklahoma, provide a direct email address for providers to submit questions and concerns.

- *Opportunities for public input*: For coverage decisions requiring rule changes, state Medicaid programs obtain public input through the rulemaking process. Some programs have developed additional opportunities for public input. Texas Medicaid, for example, posts draft policies to its website for a 2-week period, and will post a disposition of comments received.[3]

Targeted Engagement Strategies

- *Clinical experts*: Relationships with clinical experts can assist Medicaid staff in understanding key clinical and implementation issues. For example, Oklahoma Medicaid has developed a relationship with the state university system to provide expertise in assisting with policy development. Experts provide important perspectives and information, but state Medicaid staff also noted the importance of processes to minimize bias and conflicts of interests, such as the use of conflicts of interest disclosure forms, and the transparency of experts consulted in the draft policy review process.

- *Professional associations*: Three of the state Medicaid programs reviewed (Alabama, Oklahoma, Tennessee) use state staff members' relationships with professional associations to keep providers up-to-date on major policy changes, coverage determinations, and provide a platform for provider feedback. In all 3 states, a state Medicaid medical director regularly attends professional association meetings (ranging from quarterly to annual meetings) and provides Medicaid coverage policy and program updates at those venues.

State Relationships with Managed Care Plans

Given the dominant role of Medicaid managed care in Louisiana, the state scan also explored state Medicaid relationships with managed care plans, focusing on the role of managed care input on coverage policy decisions, and agency strategies to ensure consistency across FFS and managed care coverage policies.

Box D: TennCare Medical Necessity Criteria (200-13-16.05)

To be medically necessary, a medical item or service must satisfy each of the following criteria:

1. Recommended by a licensed physician or other licensed healthcare provider who is treating the enrollee
2. Required to diagnose or treat an enrollee's medical condition
3. Is safe and effective
4. Is not experimental or investigational
5. Is the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition

Managed Care Plan Engagement Strategies

State Medicaid programs use frequent, regular meetings between Medicaid and managed care plan staff to communicate upcoming policy changes, work through policy implementation issues, and seek feedback on coverage policy

development. State Medicaid staff use a range of meeting frequencies (weekly, monthly), and specific meeting compositions (chief executive officers only, medical directors only, chief financial officers only) to communicate policy changes and manage any discrepancies between FFS and managed care coverage of services.

Consistent Medicaid FFS & Managed Care Coverage

All of the state Medicaid programs that deliver services through managed care plans included in this review direct their managed care plans to follow state FFS coverage criteria. State interviewees reported that plan coverage criteria are not allowed to be more restrictive than coverage criteria established for the Medicaid FFS program. Most notably, TennCare, which is fully managed care, uses administrative rule to define required covered services across managed care plans. As described above, TennCare administrative rules set a common definition of medical necessity that includes the consideration and evaluation of evidence; defines the program's benefit package; and explicitly states which services, products, or procedures are not covered by the program.[4,7] A list of excluded services is maintained in administrative rule and must go through the legislative process for any edits or changes (TennCare Rule 1200-13-13-.10). Some services on the exclusions list only apply to adult enrollees; others pertain to adult and child populations.

In evaluating a request for services, managed care organizations (MCOs) must use specific methods in TennCare rules (1200-13-16-.01, 1200-13-16-.06) for classifying services as having A, B, C, or D level of supporting evidence based on an evidence hierarchy defined by the rules (described above).

BOX E: Florida Medicaid Medical Necessity Definition[6]

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

Discussion

This review identified core components across state coverage decision processes that can inform updates to Louisiana Medicaid's framework and process for determining coverage of medical, behavioral health, and dental services. As discussed above, it will be important for LDH leadership to be able to identify and manage potential conflicts of interest for each component of the updated framework. The following are key features for LDH leadership to consider in updating the Louisiana Medicaid coverage decision process:

- *Benefit identification*: LDH leadership could consider updating the process for benefit nominations by requiring submitters to include supporting research and other information that should be considered for a coverage request. LDH leadership could also consider increasing the accessibility of the online benefit nomination process so that it can be easily identified by stakeholders.
- *Benefit selection and prioritization*: In selecting which benefits request may serve Louisiana Medicaid enrollees the most, LDH leadership could consider the use of explicit selection and prioritization criteria to help focus resources on priority benefits in a transparent and consistent manner.
- *Evidence review*: LDH leadership could consider developing a core list of high-quality evidence, clinical practice guideline, and policy sources to standardize and maintain consistency in the coverage decision-making process and development of policies. In addition, LDH leadership could establish a hierarchy of evidence to guide the submission of high-quality research for review.
- *Policy development*: In addition to standardized processes of evidence review, Medicaid program staff have standardized process for reviewing clinical practice guidelines and other payer benefit coverage. The Medicaid program staff of the reviewed states routinely meet and discuss draft policies with medical directors from Medicaid managed care plans. LDH leadership should consider establishing regular meetings with the medical directors of contracted MCOs, both for reviewing MCO policies and for requesting review and feedback on draft policies from medical directors.
- *Post-implementation utilization review*: Reviewing the uptake of a new or revised benefit change can identify important implementation challenges and areas for policy refinement. Louisiana Medicaid leadership should consider establishing core criteria for post-implementation utilization reviews and a standard timeline for conducting such reviews.
- *Communication*: State Medicaid interviewees emphasized the value of clear and consistent communication about a well-defined coverage development process as an essential factor in promoting strong stakeholder relationships. As part of this, state Medicaid administrators have developed various avenues and methods for communicating about program updates and policy development.

Stakeholder Survey

Overview

To gather broad stakeholder input on current processes and suggestions for potential improvements to Louisiana Medicaid's coverage decision process, the Center used an online survey to solicit a diverse range of internal and external stakeholders to identify positive components and challenges, potential opportunities for improvement, and key principles to guide the development of updates to Louisiana Medicaid's framework and processes for making coverage decisions.

Methods

In collaboration with LDH staff, the Center developed an 11-question online survey instrument. Hosted on SurveyMonkey, the survey was open from October 30, 2018, through November 11, 2018. The survey was designed to elicit feedback from a broad range of stakeholders, including providers, patients and caregivers, advocates, professional and trade associations, state agency leadership and staff, and others. Potential respondents were identified through internal LDH distribution lists. The survey link was unprotected so that respondents could forward to other stakeholders, and the survey link was posted to the LDH website. In total, the survey was distributed to 832 unique email addresses.

During the 2-week data collection period, 136 individuals participated in the survey. Of these, 21 participants answered fewer than 3 questions and were excluded from the final analysis for a final response rate of 14%. Qualitative responses were coded and analyzed using Atlas.ti (analysis software), to develop high-level themes from comments collected via open-ended text boxes.

Findings

Of the 115 respondents included in the analysis, 62% were individual medical, behavioral health, or dental providers; 10% were state agency employees; and 23% represented other types of stakeholders (e.g., consumers, advocates, health plans, professional associations) (see Figure 2). The geographic distribution of survey respondents generally reflected population distribution in the state, and 19% of respondents identified themselves as representatives of organizations with statewide reach. Additionally, 58% of respondents had interacted with Louisiana Medicaid and its current coverage decision process, such as suggesting a service for coverage, contacting Louisiana Medicaid staff regarding a policy or topic, participating in a stakeholder meeting, or providing public testimony or written feedback on a policy.

The respondents who had interacted with Louisiana Medicaid and its current coverage decision process identified several areas they thought were working well, such as LDH staff accessibility for and responsiveness to stakeholder requests, ongoing efforts to improve coverage decision processes, and online forms and processes (e.g., online submission form and process, provider portals). Respondents also identified potential areas for improvement: more timely review and update of coverage policies, greater incorporation of evidence into policy development, better communication about Louisiana Medicaid's coverage decision process, and website usability.

Survey respondents identified and ranked potential key principles to guide the LDH's future work. The following were the 4 highest ranked principles, in order:

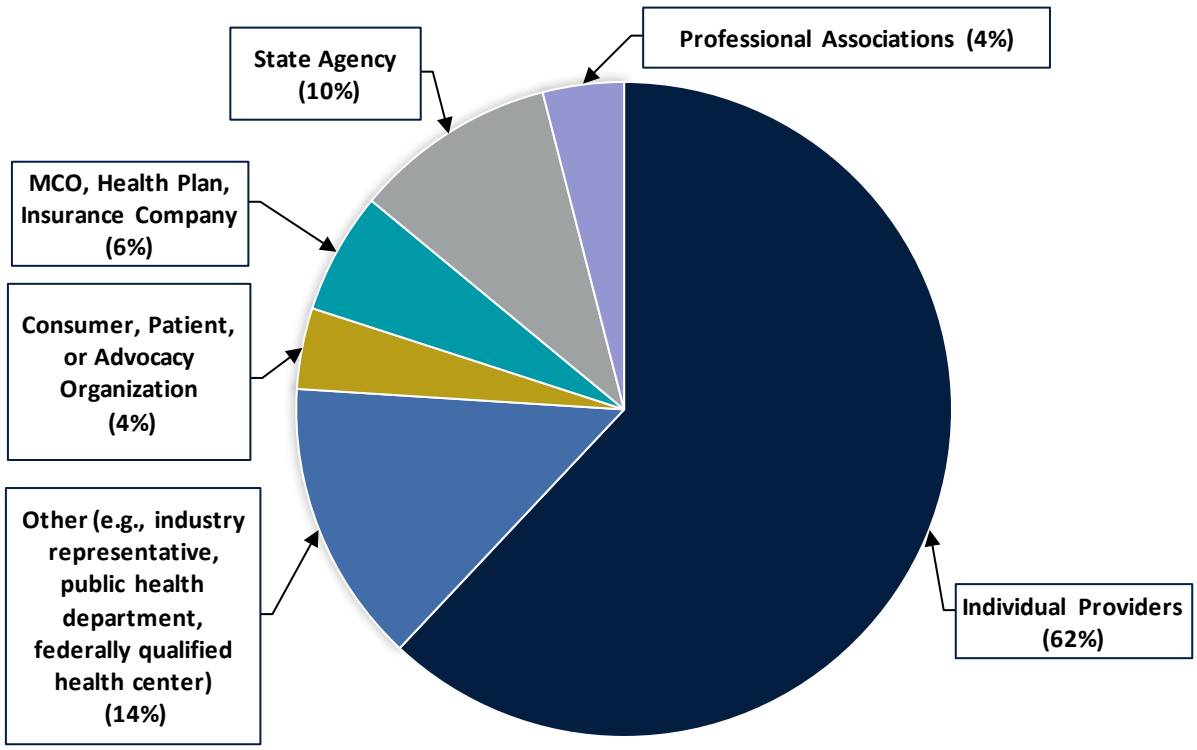
- Patient-centered
- Timely
- Evidence-based
- Accountable

The remaining 4 principles, in order, were not prioritized (understandable, transparent, cost-conscious, and standardized).

Discussion

The stakeholder survey findings represent a snapshot of provider, state agency staff, MCO, consumer and patient advocate, professional association, and other stakeholder satisfaction and concerns with Louisiana Medicaid's current process for evaluating coverage of new and existing medical, behavioral health, and dental services. The individual principles that stakeholders ranked the highest—patient-centeredness, timeliness, evidence-based, and accountability—were also strongly reflected in stakeholder comments and suggestions. LDH leadership could consider potential process updates that integrate these principles such as enhancing the accessibility of the online benefit submission process; using a core set of high-quality evidence sources for coverage development; and providing clear and frequent communication about coverage policy development processes and the status of specific benefits under review.

FIGURE 2: ONLINE SURVEY RESPONDENT STAKEHOLDER TYPES



Synthesis & Development of Framework & Process Update

The Phase I process described above resulted in the identification of best practices and core components of state Medicaid coverage decision-making processes, as well as guiding principles and stakeholder needs related to Louisiana Medicaid's process for coverage decisions. The Center synthesized this information to develop proposed updates to the framework and process for making coverage decisions for medical, behavioral health, and dental services:

Benefit Identification

Identifying potential medical, behavioral health, and dental benefits for coverage consideration is an important first step in the coverage decision process. There are various mechanisms for identifying potential benefits such as the use of data and horizon scanning, stakeholder recommendations, state legislative and federal directives, and newly released and updated billing codes. Although Louisiana Medicaid currently uses an online benefit consideration request process, agency leadership have an opportunity to improve the benefit identification process by making the online submission portal more easily accessible and clearly communicating key decision process components to stakeholders. Louisiana Medicaid leadership could choose to require submission of supporting research, and they could establish standards for evidence review. Enhanced communication and use of a standardized process to collect and evaluate evidence can increase transparency and create greater opportunities for stakeholder participation in identifying important benefits for consideration. Requiring the submission of supporting research with benefit consideration requests can help Louisiana Medicaid be more responsive to the changing health care environment.

Benefit Selection & Prioritization

After potential medical, behavioral health, or dental benefits have been identified, it is important that only benefits that are relevant to the needs of Louisiana Medicaid enrollees are selected for further review. It is also critical that benefits are ordered by priority to ensure that the most important benefits are reviewed first. Louisiana Medicaid leadership could consider using consistent and transparent criteria to select benefits for further review and developing criteria to prioritize the order in which benefits are reviewed. These process changes can increase the transparency of the coverage decision-making process, and reduce the time needed for the benefit review process.

Evidence Review

After benefits have been prioritized for further evaluation, it is standard practice among the state Medicaid agencies we reviewed to undertake a careful study of evidence to ensure informed coverage decisions. Louisiana Medicaid should develop a core set of high-quality sources for identifying evidence to use in the coverage decision process. Louisiana Medicaid leadership could consider using an evidence grading system, or other

standardized processes, to guide the review of research and to ensure the prioritization of high-quality evidence in the evaluation of benefits. Using consistent, high-quality sources for evidence will ensure that Louisiana Medicaid's coverage decisions are evidence-based and up-to-date. In addition, having clear, well-documented processes for evidence review can increase transparency and stakeholders' trust that coverage decisions are based on up-to-date information and the best possible research.

Policy Development

In addition to a review of evidence, the state Medicaid agencies we interviewed also consider clinical practice guidelines, other payers' benefit coverage, and fiscal, regulatory, and other implementation considerations when determining whether a medical, behavioral health, or dental service is covered. Medicaid agency staff take all of these factors into consideration when drafting policy language and establishing coverage criteria. In the states we reviewed, Medicaid policy development staff have established internal policy decision processes, work collaboratively with fiscal, data, and legal departments, adhere to a state's rule making process (as applicable), and collaborate with other state agencies and stakeholders to work through implementation considerations.

Post-Implementation Utilization Review

After a coverage policy has been implemented, some state Medicaid agencies periodically review utilization data to understand the general use of a new or revised benefit, and to identify any residual implementation issues such as billing inconsistencies, provider discrepancies, or general fiscal implications.

Communication

Clear communication is an important factor in engaging stakeholders that should be considered as an underlying component of the updated Louisiana Medicaid coverage decision process. Louisiana Medicaid leadership should consider establishing defined communication points along the benefit identification, evidence review, and policy development timeline at which stakeholders are updated on the progress of the benefit under review. LDH leadership should also clearly communicate the outcome of the coverage decision process once a decision has been made.

As LDH leadership continue to determine how these proposed framework and process updates will be implemented, they might identify additional components or alternative mechanisms for addressing key focus areas, as guided by the shared principles that were identified in the stakeholder survey. For each of the components of the updated framework, identifying and managing potential conflicts of interest will be essential for supporting an equitable and transparent coverage decision process. At the time of this report, the LDH was vetting potential process updates, and therefore specific details about the next phases of the project are not included in this summary.

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Appendix A
State Interview Guide

Background

Louisiana Medicaid has contracted with the Center for Evidence-based Policy (the Center) at Oregon Health & Science University to assist in making updates to the state's process for determining coverage of medical, behavioral health, and dental services. As part of this work, the Center is conducting a policy review of medical and dental services coverage determination processes in 5 states selected by Louisiana Medicaid: Alabama, Florida, Oklahoma, Tennessee, and Texas. The goal of the policy review is to present design options for updating Louisiana Medicaid's coverage decision process, including innovative practices and lessons learned from other states.

Questions

We are interested in high-level information about state benefit decision processes, best practices, and key challenges in the following focus areas:

1. Identification and selection of topics for review
2. Benefit review bodies and decision authorities
3. Key review components
    - Evidence review
    - Other payer policy review
    - Fiscal impact assessment
    - Use of data
    - Medicaid regulatory review (e.g., state plan and waiver options)
    - Implementation feasibility assessment and planning (e.g., prior authorization)
    - Post utilization review
4. Relationship between state benefit decisions and managed care plans
5. Stakeholder communication and involvement (providers, patients, and managed care plans)

Appendix B
List of State Interviewees

Alabama

Robert Moon
Chief Medical Officer
Alabama Medicaid

Barry Cambron
Director, Analytics
Alabama Medicaid

Florida

Brittney Austin
Government Analyst II
Bureau of Medicaid Policy
Florida Agency for Health Care Administration

Stephanie Clarke
Government Operations Consultant III
Bureau of Medical Policy
Managed Care Policy & Contract Development
Florida Agency for Health Care Administration

Jessica Kenny
Government Analyst
Bureau of Medicaid Policy
Florida Agency for Health Care Administration

Rebecca Bouquio
Government Analyst II
Bureau of Medicaid Policy
Florida Agency for Health Care Administration

Oklahoma

Mike Herndon
Chief Medical Officer
Oklahoma Health Care Authority

Jean Krieske
Director
Medical Administrative Support
Oklahoma Health Care Authority

Tracy Matthews
Dental Manager
Oklahoma Health Care Authority

Tennessee

David Collier
Associate Medical Director
Bureau of TennCare

Vaughn Frigon
Medical Director
Bureau of TennCare

Victor Wu
Chief Medical Officer
Bureau of TennCare

Texas

Joanna Seyller
Clinical Policy Manager
Medicaid and CHIP Services Department
Texas Health & Human Services Commission

Sheree Coleman
Project Manager – Benefit Management
Medicaid & CHIP Services Department
Texas Health & Human Services Commission