POLICY AND PROCEDURE

DEPARTMENT: Contracting and Network Development	**DOCUMENT NAME:** Network Selection and Retention
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SCOPE:
Louisiana Healthcare Connections (LHCC) Provider Consultants, Provider Data Management, Billing, Claims, and Contracting & Network Development

PURPOSE:
To establish guidelines whereby LHCC will select, recruit, and maintain provider's membership in the provider network.

POLICY:
Provider Consultants, Contracting & Network Development will be proactive in selecting and maintaining a stable network through outreach, recruitment and retention activities to ensure an adequate and accessible provider network.

PROCEDURE:
All services covered under this contract shall be accessible to plan members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area

PROVIDER SELECTION

1. The Contracting & Network Development and Provider Consultant Departments select and recruit the provider network by regularly monitoring and considering the following factors:

    a. The anticipated enrollment by parish and by GSA.

    b. The expected utilization of services, taking into consideration the characteristics and healthcare needs of LHCC members.

    c. The numbers and types (in terms of training, ~~experience~~experience, and specialization) of providers required to furnish the covered services, including ensuring female members have direct access to an in-network women's health specialist to provide routine and preventive health care services and members needing a course of treatment or regular care have direct access to specialists.

    d. The number of network providers who are not accepting new Medicaid patients.

e. The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.

f. Capacity to ensure that waiting times and access requirements for appointments do not exceed the Louisiana Department of Health and Hospitals (LDH) prescribed waiting times.

g. Diversity of the provider network.

h. Natural referral patterns.

i. Provider network compliance with LHCC Quality and Utilization Management Programs.

j. All providers must meet the State of Louisiana Credentialing Requirements including CLIA certification or waiver, if applicable, for all Lab Testing Sites.

k. All providers will be required to be in accordance with 42 CFR §438.214

2. LHCC's in and out-of-network providers shall be eligible to enroll as Louisiana Medicaid providers.

3. LHCC shall ensure that its provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. In addition LHCC shall not discriminate with respect to participation in LHCC program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a) (1) and (2)].

4. LHCC shall maintain and monitor a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical, cognitive or ~~mental~~ behavioral health disabilities [42 C.F.R. §438.206(b)(1)]. For the purposes of determining network adequacy, LHCC shall consider only those providers who meet the following criteria:~~.~~

    a. Physical health provider who have submitted at lease twenty-five (25) claims in an office setting within the prior six (6) calendar months;

b. Behavioral health provider who have submitted at lease twenty-five (25) claims in an office setting within the prior six (6) calendar months;
c. Any providers, who were newly credentialed within the prior six (6) calendar months, regardless of claim submisssions.

5. LHCC shall develop policies and procedures to support the development of a workforce and provide services to the dually diagnosed, individuals with a co-occurring developmental disability and mental health diagnosis. These policies and procedures shall include:
   a. A plan for how to improve and increase services available for individuals with behavioral health and developmental disabilities, including autism spectrum disorders, which incorporates reducing health disparities and long-range fiscal planning to support the training and fiscal sustainability of the provision of such services. This shall be submitted to LDH or its designee as part of Readiness Review for approval and annually thereafter.
   b. An annual assessment of the number of providers serving Enrollees with behavioral health and developmental disabilities and of whether the needs of this population are being met. This assessment shall include: the number of Enrollees being being served out of state due to a lack of appropriate services in state; whether these providers have waiting lists; and whether access to care standards are being met by these providers.
   c. A database of trainers, consultants, and contractors that specialize in working with Enrollees with dual diagnosis of behavioral health and developmental disabilities.
   d. Incentives for providers to attain the certification.

~~5.~~6. LHCC shall collect cultural, ethnic, racial and/or linguistic data about practitioners on a voluntary basis at least annually and during the credentialing process.

~~6.~~7. LHCC network providers shall ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities. At the request of the member, LHCC shall provide for a second opinion from a network provider, or arrange for the member to obtain one outside the network, at no cost to the member.

~~7.~~8. LHCC and its network providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and

provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by:

- Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required);
- Assessing the cultural competency of the providers on an ongoing basis, at least annually
- Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.;
- Assessing provider satisfaction of the services provided by the MCO at least annually; and
- Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments

9. LHCC shall ensure parity in determining access to out of network providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in accordance with 42 CFR §438.910(d)(3).

~~8.~~10. LHCC shall endorse real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications.

~~9.~~11. LHCC shall ensure that all participating network providers, including significant traditional providers (STPs) have knowingly and willfully agreed to participate in LHCC's network. Furthermore, LHCC shall make a good faith effort to include in its network significant traditional providers (STPs) in each GSA for the first two (2) years of operation under LHCC Contract provided that the STP: Agrees to participate as an in-network provider

and abide by the provisions of the provider contract; and Meets the credentialing requirements. 7.7.14.2. Provider types/classes eligible for participation as a STP are: Physicians, PCPs (as defined in Section §7.6.1, §7.6.2 and the Glossary); OB-GYNs, and Hospitals In the event an agreement cannot be reached and a STP does not participate in LHCC, LHCC shall maintain documentation detailing efforts that were made.

12. LHCC will maintain all correspondence relating to network development and recruitment activities for Small Rural Hospitals as defined by Rural Hospital Preservation Act of 1997, Community Service Boards, federally qualified health centers (FQHCs), rural health clinics (RHCs), family planning clinics, school based health clinics (SBHCs) and Office of Public Health (OPH). LHCC will make best efforts to include all such entities in its provider network, subject to reasonable credentialing requirements as provided by LDH.

~~10.~~13. In partnership with the Louisiana State Medical Society, we will provide funding and other support needed to develop a Clinically Integrated Network (CIN) that will enable small, rural, and independent LHCC providers to engage in more advanced VBP arrangements and improve overall quality for LHCC enrollees assigned to CIN providers.

~~11.~~14. LHCC will offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) and include them in its provider network.

a. If LHCC is unable to contract with an FQHC or RHC LHCC is not required to reimburse that FQHC or RHC without prior approval for out-of-network services unless:
    i. The medically necessary services are required to treat an emergency medical condition
    ii. FQHC/RHC services are not available through at least one MCO within LDH's established time and distance travel standards.
b. LHCC shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from LDH.
c. LHCC will reimburse contracted FQHC/RHC the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.

~~12.~~15. LHCC will contract for SBHC (certified by the LDH Office of Public Health) services - those Medicaid services provided within school settings to Medicaid eligible children under the age of 21. LHCC will offer a contract to each SBHC. The SBHC may be required to follow all of LHCC's required policies and procedures.

~~13.~~16. LHCC will offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STD, family planning [including those funded by Title X of the Public Service Act]). LHCC shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and LHCC.

~~14.~~17. LHCC will offer a contract to Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program.

~~15.~~18. LHCC will offer a contract to all providers approved by the LDH PSH Program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program.

19. In accordance with 42 CFR §438.602(b) and upon LDH implementation of a provider management system, LHCC and its subcontractors shall not enter into a network provider agreement with a provider to provide services to Medicaid beneficiaries when the provider is not otherwise appropriately screened by and enrolled with the State according to the standards under 42 CFR §455 Subparts B and E and upon implementation of appropriate systems. Such enrollment does not obligate providers to participate in the FFS healthcare delivery system.

~~16.~~ LHCC shall require unlicensed staff of entities rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services to obtain and submit NPI numbers to LHCC, as well as documentation verifying the unlicensed staff meets all qualifications and requirements for providing MHR services established by applicable Federal and State laws, rules, regulations, and the Medicaid Behavioral Health Services provider Manual, inclusive of Evidence-Based Practice (EBP) MHR services, prior to reimbursing agencies for services provided by these staff. Claims submitted for MHR services shall include rendering provider NPIs and other LHCC required identifiers regardless of whether the rendering staff is licensed or unlicensed. LHCC shall configure systems to deny claims for services when rendering providers and NPIs are denoted on claims for service that have not been

credentialed and approved by LHCC. LHCC shall submit their policies and procedures associated with this requirement to LDH or its designee for approval during Readiness Review.

20. Once providers are screened and enrolled with the State, LHCC may credential providers to verify they are qualified to perform the services they are seeking to provide and execute network provider agreements. The State may implement a NCQA-certified Credentials Verification Organization (CVO) for the credentialing and recredentialing of all Network Providers, ~~in which case LHCC must participate on the CVO credentialing committee and accept the final credentialing decisions of the CVO~~. The State's Contractor will be given at least ninety (90) Calendar Days' notice before the implementation of any CVO contract. When LDH implements a CVO, LHCC shall:

a. Accept the final credentialing decisions of the CVO
b. Within thirty (30) Calendar Days of receipt of an approved credentialing decision, load providers in its claims processing system.
c. Provide information to the State's provider management contractor on Network Providers.
~~17.~~d. Participate on the CVO's Credentialing committee to evaluate provider credentialing files (including re-credentialing files) using a peer review process. The credentialing committee is responsible for credentialing decisions which shall be accepted by LHCC.

~~18.~~21. LHCC may execute network provider agreements pending the outcome of the State screening, enrollment, and re-validation process of up to one hundred twenty (120) calendar days, but upon notification from the state that a provider's enrollment has been denied or terminated, or the expiration of the one hundred twenty (120) calendar day period without enrollment of the provider, LHCC shall terminate such network provider immediately and notify affected members that the provider is no longer participating in the network.

~~19.~~22. Prior to contracting with a network provider and/or paying a provider's claim, LHCC shall ensure that the provider has a valid National Provider Identifier (NPI) Number, where applicable, has a valid license or certification to perform services, has not been excluded or barred from participation in Medicare, Medicaid, and/or CHIP, and has obtained a Medicaid provider number from LDH upon implementation of appropriate systems. LHCC

shall comply timely with all sanctions imposed by the State on network providers, including enrollment revocation, termination, and mandatory exclusion.

~~20.~~23. LHCC shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings:

a. Revocation of the provider's home and community-based services license or behavioral health service license;
b. Exclusion or Termination from the Medicaid program;
c. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41);
d. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or
e. The Louisiana Attorney General's Office has seized the assets of the service provider.

~~21.~~24. LHCC will offer a contract to the following behavioral health provider types for the first twenty-two (22) months after integration and any extension of this requirement shall be decided by LDH:

a) Rural Health Clinics (RHC)
b) Wraparound Agencies
c) Local Governing Entities
d) Family Support Organizations
e) Providers of 1915(c), 1915(b3) and 1915(i) services
f) Methadone Clinics pending CMS approval
g) Providers of addiction services for youth and adults at all levels of care
h) Providers of Evidence Based practices (i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders©.
i) Providers trained to implement specialized behavioral health services for the at-risk youth population ager zero (0) to age six (6)

j) All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs)
k) Mental Health Rehabilitation (MHR) Agencies
l) Current LMHPs (psychologists, LCSW, LMFT, LAC, APRNs)
m) Providers trained to implement specialized behavioral services for the at-risk youth population age zero (0) to age six (6) (e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT).
n) Providers that are actively serving Act 421 Children's Medicaid Option enrollees, subject to 42 CFR 431.52.

25. LHCC shall contract with at least one (1) psychiatric residential treatment facility (PRTF) within the State with the ability to work effectively with Enrollees with dual diagnosis of developmental disabilities and behavioral health. The Contractor shall have at least one (1) Therapeutic Group Home (TGH) within the state with the ability to work effectively with Enrollees with dual diagnosis of developmental disabilities and behavioral health.

26. LHCC shall have community providers (i.e. psychiatrist, psychologist, social workers, advanced practice registered nurses [APRNs], mental health rehabilitation [MHR] providers, Wrap-around agencies [WAAs], etc.) within the State with the ability to effectively work with Enrollees with a dual diagnosis of developmental disabilities and behavioral health.

27. Unlicensed staff shall mandatorily complete training that addresses dual diagnosis and shall receive certification.

~~22.~~28. LHCC shall demonstrate that there are sufficient Indian Health Care Providers (IHCPs) participating in the provider network to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services. The IHCPs, whether participating in LHCC's network or not, shall be paid for covered services provided to Indian members who are eligible to receive services from such providers as follows:

a. At a rate negotiated between LHCC and the IHCP; or
b. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that LHCC would make for services to a participating provider which is not an IHCP; and

c. Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and §447.46.

~~23.~~29. LHCC shall permit any Indian who is enrolled with LHCC and is eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her PCP, and as long as that provider has capacity to provide the services. LHCC shall permit Indian members to obtain services covered under the contract from out-of-Network IHCPs from whom the member is otherwise eligible to receive such services. Where timely access to covered services cannot be ensured due to few or no IHCPs, LHCC will be considered to have met the requirement in paragraph 42 CFR §438.17(b)(1) if:

a. Indian members are permitted by LHCC to access out-of-State IHCPs; or
b. If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).

LHCC shall permit an out-of-network IHCP to refer an Indian member to a network provider.

~~24.~~30. LHCC shall work with behavioral health providers to ensure behavioral health services are offered to address the needs of adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring mental health and substance use disorders, and all eligible children, including those eligible for the CSoC, which includes children eligible for 1915c and 1915b3 waiver services. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.

~~25.~~31. LHCC shall ensure its provider network offers an appropriate range of preventive and specialty behavioral health services as reflected in the LDH Behavioral Health Provider Manual Service Definitions Manual that is adequate for the anticipated number of members for the service area, including compliance with the waivers and Medicaid State Plan requirements. The network shall be developed to meet the needs of members, including but not limited to providing assessment to identify and treat the behavioral health needs of members with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.

~~26.~~32. LHCC shall design their provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when

lower cost community-based services are available and eliminates preventable hospital admissions. The MCO shall coordinate with other state agencies, as appropriate, to match services to meet behavioral health needs in the community with services and supports to meet the members other needs in the community, such as I/DD.

~~27.~~33. LHCC shall design their provider network to increase the emerging use of peers as providers. This includes peers providing required peer services for youth, adults and parents/families served in the community and residential settings, peer services as approved by LDH as cost-effective alternative services, and peer support specialists with OBH approved credentials to serve as qualified providers (i.e., required peer services such as Youth Support Training and Parent Support Training), in lieu of peer services, and peers certified to serve as qualified providers of other state plan/waiver services (including, but not limited to, PSR or CPST).

~~28.~~34. LHCC shall ensure that within the provider network, members enrolled in 1915(c) (CSoC) home and community based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.

~~29.~~35. LHCC shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services during evenings and weekends for members or their families/caregivers who are unavailable for appointments during traditional business hours.

~~30.~~36. LHCC shall work with LDH and other MCO's to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.

~~31.~~37. LHCC will include LDH certification requirements in its credentialing and contracting requirements for all specialty behavioral health providers;

38. LHCC shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week coinciding with LDH effective date of behavioral health carve-in. The community-based crisis response system may include, but is not limited to, an on-call, 24-hour crisis hotline, warm line, crisis counseling, behavioral health management and intervention, mobile crisis teams, collaboration with law enforcement crisis stabilization in

alternative settings, and crisis stabilization/crisis receiving centers for adults. LHCC shall work with LDH and other entities as identified by LDH to develop a robust continuum of behavioral health crisis responses that includes services ranging across the crisis continuum to include the following (Model Contract 2.9.25.13.1-2.9.25.13.5)

- Crisis prevention and crisis planning by outpatient treatment providers
- Early crisis intervention by outpatient treatment providers
- Acute crisis intervention
- Crisis treatment (including alternatives to inpatient treatment
- ~~32.~~ Post-crisis supports and strategies to prevent need for extended inpatient or admission to other congregate living.

~~33.~~39. If shortages in provider network sufficiency are identified by LDH, LHCC shall conduct outreach efforts approved by LDH, and take necessary actions to assure member access to medically necessary behavioral health services. LHCC shall execute an ad-hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need, In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through LHCC, including meals and lodging as appropriate.

~~34.~~40. If LHCC declines to include individual providers of behavioral health services or groups of behavioral health providers in its network, it shall provide written notification to LDH and give the affected provider written notice of the reason(s) within fourteen (14) calendar days of the decision to decline participation.

~~35.~~41. If shortages in provider network sufficiency are identified by LDH, LHCC shall conduct outreach efforts approved by LDH, and take necessary actions, including use of enhanced provider reimbursement rates, to assure member access to medically necessary behavioral health services. LHCC shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. LHCC will ensure the cost to the member or the state is no greater than it would be if the services were furnished within the network. Transportation will be provided and reimbursed through Medicaid when eligible; otherwise, LHCC shall be responsible for costs of necessary transportation in this circumstance including meals and lodging as appropriate.

~~36.~~42. LHCC will request approval from LDH, LDH-BHSF, to place youth in out-of-state facilities for treatment purposes. LHCC will also provide evidence of what efforts are being made to return these youth to the state and their homes.

~~37.~~43. In the first six (6) months of the contract amendment, LHCC will have no corrective action plans placed on them due to the number of youth placed out-of-state; however, thereafter there will be remediation should the number exceed ten (10) a ceiling to be established by LDH out-of-state youth per contract year unless evidence is presented that indicates the out-of-state provider is the most appropriate and necessary option to treat the specialty needs of the member.

~~38.~~44. LHCC shall require behavioral health providers to screen for basic medical issues, such as utilizing the healthy living questionnaire 2011 or the PBHCI medical screening short form.

~~39.~~45. LHCC shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability. LHCC shall report the number of out-of-state placements as specified by LDH. LDH may require LHCC to take corrective action in the event LDH determines the MCO's rate of out-of-state placements to be excessive

~~40.~~46. For services that do not meet the definition of emergency services, LHCC is not required to reimburse more than 90% of the published Medicaid rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts (as defined in Glossary) to include the provider in their network (except as noted in Section 9.2). LHCC may require prior authorization of out-of-network services, unless services are required to treat an emergency medical condition

~~41.~~47. LHCC will ensure in-network providers do not intentionally segregate LHCC members in any way from other patients receiving care in the provider's office. In addition, LHCC will ensure in-network providers provide care without regard to LHCC member's race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status or physical or mental disability. Furthermore, as an in-network provider, LHCC contract template requires provider to abide by these requirements.

~~42.~~48. When LHCC becomes aware of a behavioral health provider's failure to comply with mainstreaming, LHCC shall develop a formal corrective action plan with the behavioral health provider within thirty (30) calendar days and notify LDH-OBH in writing.

~~43.~~49. LHCC shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.

~~44.~~50. It shall be explained to providers that LHCC may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical records information required to update the member's medical record.

~~45.~~51. If Provider Consultants and Contracting & Network Development Departments decline to include a provider or groups of providers in its network the Provider Consultants and Contracting & Network Development Departments shall give the affected providers written notice of the reason(s) for the decision within fourteen (14) calendar days of its decision. This notification will not be construed to mean that LHCC will contract with Providers beyond the number necessary to meet the needs of its members or preclude LHCC from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

~~46.~~52. Provider Network Adequacy and Capacity Reports are run at least on a quarterly basis or upon LDH request. If a deficiency is identified or there is a material change to the network, Provider Consultants and Contracting & Network Development Departments will recruit qualified providers to ensure an adequate and accessible provider network. LHCC shall notify LDH within one (1) business day of any material changes to the provider network or, if applicable, to any subcontractor's provider network.

a. Members linked to a PCP that is no longer able to provide services, will be notified through mail outs that the practitioner is no longer in our network. The members will also be advised to choose another PCP in a timely manner or one will be chosen for them.
b. Specialists that are no longer able to provider services will be removed from our provider directory. LHCC will also ensure that the loss of the provider causes no obstacles to care for members.

~~47.~~53. LHCC shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in value added benefits and services, payments, or eligibility of a new population. When LHCC has advance knowledge that a material change will occur, we will submit a request for approval of the material change in the provider network, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change. Such request will include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them. If LDH does not respond within thirty (30) calendar days of the request, then the notice is deemed approved.

~~48.~~54. LHCC shall notify the LDH/BHSF/Medicaid Managed Care Section within one (1) business day of becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify LHCC, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include:

a. Information about how the provider network change will affect the delivery of covered services, and
b. LHCC's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

~~49.~~55. LHCC shall provide written notice to LDH, no later than seven (7) business days of any network provider contract termination that materially impacts LHCC's provider network, whether terminated by LHCC or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as:

1. Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered.

2. A decrease in the total number of PCPs by more than five percent (5%);

3. A loss of all providers in a specific specialty where another Provider in that specialty is not available within sixty (60) miles;

4. A loss of any participating specialist that may impair or deny the member's adequate access to providers

5. A loss of a hospital in an area where another health plan hospital of equal service ability is not available as required by access standards specified by the ~~RFP~~Model Contract; or

6. Other adverse changes to the composition of the network which impair or deny the members' adequate access to in-network providers.

7. If LHCC has prior notice of the material change to the network, LHCC will submit a request for approval 60 calendar days prior to material change. Request must include description of any short term gaps caused by the change and alternatives that will be used to fill them.

~~50.~~56. As it pertains to a material change in the network for behavioral health providers, LHCC shall also:

a. Provide written notice to LDH-OBHLDH, no later than seven (7) calendar days of any behavioral health network provider contract termination that materially impacts the provider network, whether terminated by LHCC or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those previously noted include:
    - A decrease in behavioral health provider type by more than five percent (5%);
    - A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or
    - A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by LDH-OBHLDH.

b. LHCC shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.

c. When LHCC has advance knowledge that a material change will occur to its network of behavioral health providers, LHCC must submit a written request for approval of the material change in their provider network to LDH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change.

d. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including:

- Detailed information identifying the affected provider;
- Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category (e.g., children eligible for the CSoC, adults eligible for the 1915(i), etc.);
- Location and identification of nearest providers offering similar services; and
- A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.

e. LHCC shall notify LDH in writing within five (5) calendar days if a behavioral health subcontract fails to meet licensing criteria, or if they recommend terminating, suspending, limiting, or materially changing a qualified behavioral health service provider or WAA subcontract and shall obtain written approval from LDH.

f. If a provider loss results in a material gap or behavioral health network deficiency, LHCC shall submit to LDH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to appropriate alternative behavioral health service providers in accordance with the network notification requirements.

g. LHCC shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by LDH (e.g., name, Title XIX or Title XXI status, date of birth, services member receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).

~~51.~~57. In the event that a material change to the provider network affects the quality of member care, LHCC shall address the change through new contracts and Single Case Agreements.

~~52.~~58. Provider Consultants and Contracting & Network Development Departments will recruit physicians through such means as:

a. Conducting targeted provider recruitment, which includes identifying providers through sources such as the State Board of Medical Examiners and local Medical Societies.
b. Recommendations from members, community based resources and network providers in the service area.
c. Asking providers to accept more LHCC members.
d. Identifying out of network providers utilized by LHCC members in the past.

~~53.~~59. LHCC shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this ~~RFP~~ Model Contract to LDH for prior review and approval. LDH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this ~~RFP~~Model Contract. All subcontracts executed by LHCC shall meet the terms and conditions listed in ~~Section 25 of~~ the ~~RFP~~Model Contract.

~~54.~~60. In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, LHCC shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which LHCC represents or agrees that it will not contract with another provider. LHCC shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

~~55.~~61. **Physician Incentive Plans:**

a. In accordance with 42 CFR §422.208 and §422.210, LHCC may operate a Physician Incentive Plan, but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.
b. LHCC's incentive plans for its network providers/subcontractors shall be in compliance with 42 CFR §438.6(h), §422.208 and §422.210.
c. Any sub-capitation arrangement with contracted providers is considered a provider incentive plan and subject to all requirements of Physician Incentive Plans.
d. LHCC shall submit any information regarding the incentive plans as may be required by LDH. For this proposal LHCC must submit all of the information

specified in Section ~~9.8~~2.17.4 and ~~Appendix PP~~The MCO Manual. LHCC shall obtain approval from LDH prior to implementation of the incentive plan.

e. LHCC shall receive prior to LDH approval of the Physician Incentive Plan and shall submit to LDH any contract templates that involve an incentive plan for review as a material modification. LHCC shall disclose the following:
    i. Services that are furnished by a physician/group that are covered by any incentive plan;
    ii. Type of incentive arrangement, e.g. withhold, bonus, capitation;
    iii. Percent of withhold or bonus (if applicable);
    iv. Panel size, and if patients are pooled, the approved method used; and
    v. If the physician/group is at substantial financial risk, the entity must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

f. LHCC shall provide the information specified in 42 CFR §422.210(b) regarding its physician incentive plans to any Medicaid member upon request.

g. The proposed monetary value of these incentives and/or enhanced payments will be considered a binding contract deliverable (as referenced in ~~2015 RFP - Appendix PP~~The MCO Manual). If for some reason, including but not limited to lack of provider participation or performance, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require LHCC to provide an alternate benefit of equal and/or may conduct a reconciliation for the amount unexpended.

PROVIDER RETENTION

1. LHCC Contracting & Network Development and Provider Consultants Specialists use the following list of methods to retain providers:
    a. on-time payments
    b. simple administrative procedures
    c. non-bureaucratic preauthorization procedures
    d. use of ethnically diverse providers and community leaders, on physician committees such as credentialing, UM, and Quality
    e. Provider services including
        i. Education and training for Providers and office staff such as:
            1. orientation
            2. quarterly provider meetings

3. customized one on one training
4. PCP monthly visits as scheduled or requested by a Provider Consultants Specialist

ii. Annual provider retreats

iii. Website access which includes but is not limited to:

1. eligibility verification
2. provider manual availability
3. Authorization access
4. Claims payment status and review
5. Code auditing software

iv. Physician annual survey giving providers the opportunity to help improve LHCC processes and assist with future program developments

v. Toll free telephone hotline

vi. Quality Improvement Programs

f. Market competitive reimbursement and compensation models

g. Provider Incentive payments above the La Medicaid Fee Schedule. Such incentive payments shall be made specific to:

i. Incentivize primary care physicians to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations specific to STIs.

ii. OB/GYN Providers for healthy pregnancies and reduced NICU stays

2. LHCC Provider Data Management shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers.

3. If LHCC becomes aware if any of its existing subcontractors failure to comply with requirements regarding barriers to care, LHCC will take corrective action within thirty (30) calendar days.

4. When LHCC has advance knowledge that a material change will occur, LHCC must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change.LA.CONT.23 shall serve as the basis for provider termination procedures.

5. In the event of a material change to the network, LHCC will identify any short-term gaps and work to ensure continuity of care for members through new contracts and single case agreements.

6. LHCC shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils and Areas on Aging and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

7. LHCC will make good faith efforts to execute contracts with existing Medicaid providers who request participation in LHCC network and shall track these contracting efforts, provided however, that LHCC may limit participation to the extent necessary to meet the needs of the members or to control costs and quality consistent with its responsibilities to LDH. Additionally, LHCC will make good faith efforts to contract with Significant Traditional Providers and will track these efforts. If LHCC declines requests of individuals or groups of providers to be included in LHCC network, LHCC will give the requesting providers written notice of the reason for its decision within fourteen (14) calendar days of the decision.

Non-Emergency Medical Transportation

1. LHCC will be responsible for all necessary Non-Emergency Medical Transportation for its members except those members residing in an institution. This includes transportation to both services covered within the scope of current ~~RFP~~ Model Contract and all state plan serves currently excluded, such as, but not limited to dental and behavioral health.

2. For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, LHCC shall require its transportation contractor to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.

3. If a member requests a provider who is located beyond access standards, and LHCC has an appropriate provider within its network who accepts new patients, it shall not be considered a violation of the access requirements for LHCC to grant the member's request. However, in

such cases LHCC shall not be responsible for providing transportation for the member to access care from this selected provider, and LHCC shall notify the member in writing as to whether or not it will provide transportation to seek care from the requested provider.

Laboratory

1. LHCC will ensure that all laboratory testing sites providing services must have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.

REFERENCES:
LA.PRVR.23, 42 CFR §422.208, §422.210, §438.6(h), §422.208, §422.210 §438.214; §438.12 §438.210 Title XIX; Title XXI; Model Contract~~RFP Section 7 and 25~~

ATTACHMENTS:

AppendixQ_PhysicianIncentivesRules.pdf

DEFINITIONS:
STPs are defined as including:
Physicians, PCPs (as defined in Section §7.6.1, §7.6.2 and the Glossary of the ~~RFP~~Model Contract); OB-GYNs, and Hospitals

REVISION LOG

REVISION	DATE
Added item "5" under Provider Retention	11/12/13
Added items "a" and "b" under item 12 under Provider Selection	11/12/13
Added item 14" under Provider Selection	11/12/13
• Changes-Added language regarding OON provider enrollment in Medicaid, rural hospital definition update, basic behavioral health services rendered by FQHCs and RHCs, 90% OON reimbursement	11/2014

language, PCP and specialist service cessation language, material network change and gap language, major subcontract review language, non-exclusivity language, provider incentive language, other service provider encouragement language, and language regarding good faith efforts to contract with existing Medicaid providers requesting participation in the network, as well as timing for notification if participation is denied.	
• Added Provider Selection section #19: RFP requirements – 6.10; 7.6.1;7.8.10; 7.8.11;7.8.13; 7.11;9.3.2; 9.8.1-9.8.5	05/2015
• Added RFP Requirements for BH Carve-In: 7.6.1.1.1; 7.7; 7.8.2; 7.8.9; 7.8.12; 7.11; 7.12; 7.13.10; 7.13.12	07/2015
• RFP 9.2; Grammatical edits & change DHH to LDH	09/2016
• RFP 7.6.1.1 – Update from LDH to include Ryan White clinics	10/2016
• RFP 7.1, 7.6 & added reference to 42 CFR 438.210(a)(2)	11/2016
• RFP 7.11.1 – Added language to cover requirements for material change in provider network	12/2016
• RFP 7.8.15 – RFP Amendment for 2018 from LDH & Grammatical Edits	12/2017
• RFP 7.1, 7.6 – RFP Amendment 12 for 2019	07/2018
• RFP 7.6.1.6, 7.8.14.3, 7.8.14.4, 7.8.14.5, 7.8.14.8, 7.8.14.12	05/2019
• No revisions	02/2020
• Revised for RFP Amendment 3 Attachment B3 for 7.6.1.6 that includes reference to 42 CFR 431.52.	11/2020
• Added "LHCC shall collect cultural, ethnic, racial and/or linguistic data about practitioners on a voluntary basis at least annually and during the credentialing process."	5/2021
• Revised to add Model Contract language 2.6.8.2.6, 2.9.25.13.1-2.9.25.13.5	~~05~~12/2022

POLICY AND PROCEDURE APPROVAL

POLICY AND PROCEDURE

DEPARTMENT: Contracting and Network Development	**DOCUMENT NAME:** Network Selection and Retention
PAGE: 24 of 24	**REPLACES DOCUMENT:**
APPROVED DATE: 10/2011	**RETIRED:**
EFFECTIVE DATE: 02/2012, 2/15, 12/15	**REVIEWED/REVISED:** 11/13, 11/14, 05/15, 07/15, 09/16, 10/16, 11/16, 12/16, 12/17, 07/18, 05/19, 02/20, 11/20, 5/21, 5/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.CONT.02

The electronic approval retained in Archer is considered equivalent to a physical signature.