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DEPARTMENT: Network Development and Contracting	**DOCUMENT NAME:** Network Adequacy
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EFFECTIVE DATE: 02/2011, 2/15, 12/15	**REVIEWED/REVISED:** 11/13, 11/14, 2/15, 7/15, 07/16, 11/16, 06/17; 06/18; 05/19, **01/20**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.CONT.01

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SCOPE:
This policy and procedure applies to Louisiana Healthcare Connections ("LHCC") Network Development and Contracting, and Provider Relations departments.

PURPOSE:
To **outline and** define the **mechanism utilized to monitor the type, number and geographic distribution of Primary Care Providers (PCP), Behavioral Health practitioners and high-volume and high-impact specialists in order to monitor the** ~~network~~ adequacy **of its network and how effectively the network meets the needs, preferences and diversity of its membership.** ~~standards that~~ LHCC must meet and/or exceed in order to comply with its contractual requirements with the State of Louisiana's Department of Health and Hospitals ("LDH"), and to identify the health plan departments and staff responsible for meeting, measuring, monitoring and reporting on the adequacy of the health plan's network to its senior management team.

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POLICY:
In compliance with its contract with LDH, LHCC will establish, maintain and monitor a network of Affiliated Providers that is sufficient to provide adequate access to all Covered Services taking into consideration: the anticipated number of members for the health plan, the expected utilization of services, the number and types of providers necessary to furnish the Covered Services, the number of Affiliated Providers with closed panels; and the geographic location of the Affiliated Providers and health plan members. This means at a minimum, LHCC shall have signed contracts with the specialty type providers listed in the Network Provider Companion Guide who accept new members and are available on a referral basis and/or in compliance with access and availability requirements.

PROCEDURE:
1. LHCC will develop its network adequacy standards based on the requirements described in the Provider Network Companion Guide in its contract with LDH or, if the contract does not define the requirements, based on generally accepted standards for accessibility so as to provide a network with access at least equal to, or better than, community norms.

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2. The network shall provide sufficient personnel for the provision of all covered services, including emergency medical care on a 24-hour-a-day, 7-day-a-week basis. The network shall provide core benefits and services within designated time and distance limits.

3. LHCC shall provide access to specialty providers, as appropriate, for all members. In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, LHCC will have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs. Including specialists with pediatric expertise for children/adolescents when the need for pediatric care is significantly different from the need for adult specialty care. The network shall include access to home health agencies, complying with any applicable federal requirements with respect to such agencies, as amended.

4. LHCC shall require all providers to adhere to all requirements set forth in the contract with the State including the Americans with Disabilities (ADA) requirements, and provide physical access for Medicaid members with disabilities. All efforts shall be made to preserve LDH product attachment in the standard contract.

5. LHCC will provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.

6. LHCC shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. LHCC shall provide updated GEO coding to LDH quarterly, or upon material change (as defined in the Glossary) or upon request.

7. LHCC will assess its network adequacy using the following methods and tools:

    a. At least annually, LHCC assesses the availability of practitioners within its delivery system including numbers, geographic location

and cultural diversity and analyze performance against the standards as defined below. Data sources may include but are not limited to: self-reported member data such as satisfaction survey results, geo-access reporting, provider panel assignments, and complaints/grievances regarding satisfaction with physician availability, 'secret shopper' or onsite site surveys.

b. LHCC will monitor against the following quantifiable and measurable standards:

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Provider Network – Geographic and Capacity Standards

Type	Ratio (Provider: Member)	Rural Parishes		Urban Parishes		Notes
		miles[2]	minutes[2]	miles[2]	minutes[2]	
Primary Care[1]						
Adult PCP access (for members 21 and over) [3]						
Family/General Practice; Internal Medicine; FQHCs; RHCs; Physician Extenders: Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services to adults.	Physicians: 1:2,500 adult members Physician extenders: 1:1,000 adult members	30	60	10	20	PCP mileage and time network standards are applied across these provider types collectively. Only include physicians that have agreed to accept full PCP requirements
Pediatric PCP access (for members under age 21)[3]						

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Pediatrics; Family/General Practice; Internal Medicine; FQHCs; RHCs; Physician Extenders: Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services to adults.	Physicians: 1:2,500 adult members Physician extenders: 1:1,000 adult members	30	60	10	20	PCP mileage and time network standards are applied across these provider types collectively. Only include physicians that have agreed to accept full PCP requirements.
Hospitals						
Acute Inpatient Hospitals		30	60	10	20	
Ancillary						
Laboratory		30	60	20	40	
Radiology		30	60	20	40	
Pharmacy		30	60	10	20	
Hemodialysis centers		30	60	10	20	
Dental - Pediatric3		30	60	10	20	

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Type	Ratio (Provider: Member)	Rural Parishes		Urban Parishes		Notes
		miles²	minutes²	miles²	minutes²	
Specialty Care						
OB/GYN [1]		30	60	15	30	
Allergy/Immunology	1:100,000	Travel distance does not exceed 60 miles for at least 75% of members and 90 minutes for 100% of members		Travel distance does not exceed 60 miles for at least 75% of members and 90 miles for 100% of members		
Cardiology	1:20,000					
Dermatology	1:40,000					
Endocrinology and Metabolism	1:25,000					
Gastroenterology	1:30,000					
Hematology/Oncology	1:80,000					
Nephrology	1:50,000					
Neurology	1:35,000					
Ophthalmology	1:20,000					
Orthopedics	1:15,000					
Otorhinolaryngology/Otolaryngolo	1:30,000					
Urology	1:30,000					

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Behavioral Health						
Psychiatrists						
Psychiatrists		30	60	15	30	
Behavioral Health Specialists (adult)						
Advanced Practice Registered Nurse (Behavioral Health Specialty; Nurse Practitioner or Clinical Nurse Specialist); or Medical or Licensed Psychologist; Licensed Clinical Social Worker		30	60	15	30	Behavioral Health specialist network adequacy standards are applied across these provider types collectively as compared to residences of adult members

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Type	Ratio (Provider: Member)	Rural Parishes		Urban Parishes		Notes
		miles^2	minutes^2	miles^2	minutes^2	
Behavioral Health Specialists (pediatric)						
Advanced Practice Registered Nurse (Behavioral Health Specialty; Nurse Medical or Licensed Licensed Clinical Social Worker		30	60	15	30	Behavioral Health specialist network adequacy standards are applied across these provider types collectively as compared to residences of pediatric members
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)						
Psychiatric Residential Treatment Facility Psychiatric Residential Treatment Facility						PRTF network standards are applied across these provider types

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Psychiatric Residential Treatment Facility Other Specialization		Travel distance to a PRTF shall not exceed 200 miles or 3.5 hours from the member's residence				collectively as compared to residences of all pediatric members.
Substance Use Residential Treatment Facilities - Adult Population						
ASAM Levels 3.3/ 3.5		30	60	30	60	
ASAM Level 3.7		60	90	60	90	
ASAM Level 3.7-WM		60	90	60	90	
Substance Use Residential Treatment Facilities - Adolescent Population						
ASAM Level 3.5		60	90	60	90	
Psychiatric Inpatient Hospital Services						
Hospital, Free Standing		90	90	90	90	Psych inpatient network standards are applied across these provider types collectively as compared to residences for all members.
Hospital, Distinct Part Psychiatric Unit						

[1] For purposes of assessing network adequacy for OB/GYN specialty services, access standards are established based on female members age 21 and over. The

[2] Unless otherwise specified in this Appendix, MCO must demonstrate that 100% of applicable members (adult or pediatric) have access to network providers for the type of service specified within the identified miles or minutes standard from the member's residence.

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[3] For purposes of reporting network adequacy for both physical and behavioral health services, adult is defined as members age 21 and over, pediatric is defined as members under age 21.

LDH reserves the right to add additional specialty types as needed to meet the needs of the member population.

Travel distance requirements for all Specialized Behavioral Health Providers applies to Rural and Urban areas for 90% of all members, except for ASAM 3.3, 3.5, 3.7 co-occurring, 3.7 WM, which applies to 90% of adult members.

PRTF Access: Access and adequacy is based on availability of in-state PRTF's unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member.

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Member linkages to Primary Care providers shall be submitted to LDH weekly as described in the MCO Systems Companion Guide.

LHCC will provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by LDH the MCO does not meet the access standards specified in the Contract.

Access standards to specialists that cannot be met may be satisfied utilizing telemedicine with prior LDH approval.

Members determined to need a course of treatment or regular care monitoring, will be allowed to directly access a specialist as appropriate for the member's condition and identified needs. LHCC will identify a specialist in-network, whenever possible. If an in-network provider is not available, LHCC will make arrangements for the member to see an out-of-network provider until such a provider is under contract.

Request for exceptions as a result of prevailing community standards for time and distance accessibility standards will be submitted in writing to LDH for approval. There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.

- **Time and Distance to Lab and Radiology Services.** Exceptions for community standards shall be justified, documented and submitted to LDH for approval. Other medical service providers participating in the MCOs network also must be geographically accessible to MCO members as outlined in the RFP.

Ensuring Availability of Specialty Care Practitioners

1. At least annually, Plan assesses the availability of high-volume and high-impact specialty care practitioners (SCP) within its delivery system, including numbers and geographic distribution for high-volume and high-impact SCPs and analyzes performance against the standards as defined

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below. Standards are realistic for the Plan's service area and delivery system and consider clinical safety; standards may differ for rural, suburban and urban areas, if applicable, for the plan service area.

- **a. High-volume SCPs are identified by volume of claims or episodes of care, and include obstetrics/gynecology at a minimum;**
- **b. High-impact SCPs are identified as the practitioner types that treat conditions with high mortality and morbidity rates, and include oncologists at a minimum.**
- **c. Data sources may include but are not limited to: network adequacy reports/Geo Access mapping and self-reported member data such as satisfaction survey results or complaints/grievances regarding satisfaction with physician availability.**
- **d. Number and geographic distribution may be expressed in one or more of the following ways:**
  - **i. The percentage of members who have a high-volume and high-impact SCP of each type within a certain number of miles and/or acceptable driving times, in minutes; The ratio of member-to-high-volume SCP availability in each area and a determination of acceptable driving times to specialty care sites and/or;**
  - **ii. The percentage of open high volume SCP practices within each geographic area;**
  - **iii. The rate of members who report that it is "always" or "usually" easy to get appointments with specialists, in addition to analysis of SCP availability by geographic area (when applicable, the Plan may also use the comparable question in CAHPS)**

2. Plan will establish quantifiable and measurable standards for number of high-volume SCPs:

Maximum Number of Members per Provider by Specialty

Specialty	Number of Members

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Allergy & Immunology	**1 per 100,000**
Cardiology	**1 per 20,000**
Dermatology	**1 per 40,000**
Endocrinology	**1 per 25,000**
Gastroenterology	**1 per 30,000**
General Surgery	**1 per 15,000**
Nephrology	**1 per 50,000**
Neurosurgery	**1 per 45,000**
Oncology/Hematology	**1 per 80,000**
Ophthalmology	**1 per 20,000**
Orthopedic Surgery	**1 per 15,000**
Otolaryngology	**1 per 30,000**
Urology	**1 per 30,000**

3. Plan will establish quantifiable and measurable standards for the geographic distribution of SCPs: travel distance not to exceed 60 miles for at least 75% of members and 90 miles for all members.

Practitioner Type	Urban Standard	Rural Standard
OB-GYNs	**2 within 15 miles**	**2 within 30 miles**
Dermatologists	**2 within 15 miles**	**2 within 30 miles**
Cardiologists	**2 within 15 miles**	**2 within 30 miles**
Otolaryngologists	**2 within 15 miles**	**2 within 30 miles**
Orthopedists	**2 within 15 miles**	**2 within 30 miles**
Oncologists	**2 within 15 miles**	**2 within 30 miles**

Ensuring Availability of Behavioral Health Practitioners

1. **At least annually, Plan assesses the availability of high-volume behavioral healthcare practitioners within its delivery system, including numbers and geographic distribution, and analyzes performance against the standards as defined below. Standards are realistic for the Plan's service area and delivery system and consider clinical safety; standards may differ for rural, suburban and urban areas, if applicable for the Plan service area.**

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a. **High-volume behavioral healthcare practitioners are identified by volume of claims or episodes of care, or the practitioner types most likely to provide services to the largest portion of members.**

b. **Data sources may include but are not limited to: network adequacy reports/Geo Access mapping and self-reported member data such as satisfaction survey results and/or complaints/grievances regarding satisfaction with practitioner availability.**

c. **Number and geographic distribution may be expressed in one or more of the following ways:**
   - **The percentage of members who have a high-volume behavioral healthcare practitioners of each type within a certain number of miles and/or driving times, in minutes.**
   - **The ratio of member-to-behavioral healthcare practitioner availability in each area.**

2. **Plan establishes quantifiable and measurable standards for number of behavioral healthcare practitioners.**

Practitioner Type	Ratio
Psychiatrists	2 per 1,000 members
Clinical Psychologists	2 per 1,000 members
Masters Level Clinicians	5 per 1,000 members

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3. **Plan establishes quantifiable and measurable standards for the geographic distribution of behavioral healthcare practitioners. Travel, distance shall not exceed 30 miles for 90% of rural members and shall not exceed 15 miles for 90% of urban members.**

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Practitioner Type	Distance
MD & Non-MD Behavioral Health Specialists	1 within 30 Miles for Rural Members
MD & Non-MD Behavioral Health Specialists	1 within 15 Miles for Urban Members

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4. **Management of the behavioral health benefit was integrated to the Plan effective September 1, 2018.**

Provider Network – Appointment Availability Standards

Provider/Facility Type	Standard
Emergencies and Urgent Care	
Emergency Care	24 hours, 7 days/week within 1 hour of request
Urgent Non-emergency Care	24 hours, 7 days/week within 24 hours of
Primary Care	
Non-Urgent Sick	72 hours
Non-Urgent Routine	6 weeks
After Hours, by phone	Answer by live person or call-back from a designated medical practitioner within 30
Prenatal Visits	
1st Trimester	14 days
2nd Trimester	7 days
3rd Trimester	3 days
High risk pregnancy, any trimester	3 days
Specialty Care	
Specialist Appointment	1 month
Waiting Room Time	
Scheduled Appointments	<45 minutes
Accepting New Patients	
The practitioner office is open to new patients	Provider is listed in directory and/or registry file as open
Specialized Behavioral Health Providers	
Non-Urgent Routine	14 days
Urgent Non-emergency Care	48 hours
Psychiatric Inpatient Hospital (emergency involuntary)	4 hours
Psychiatric Inpatient Hospital (involuntary)	24 hours

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Psychiatric Inpatient Hospital (voluntary)	24 hours
ASAM Level 3.3, 3.5 & 3.7	10 business days
Withdrawal Management	24 hours when medically necessary
Psychiatric Residential Treatment Facility	20 calendar days

- ***Hospital Access.*** Usual and customary, not to exceed 10 miles or 30 minutes, except in rural areas where the standard is 30 miles. In addition, LHCC will include, at a minimum, access to the following:
    i. One (1) hospital in each parish in their service area, if a hospital is available, for the provision of inpatient and outpatient services, including emergency room services (free standing psychiatric hospitals and distinct part psychiatric hospitals are excluded from this requirement);
    ii. Tertiary hospital services, available 24 hours per day, for:
        - Level III Obstetrical services (LHCC defines this as a hospital that can provide high risk deliveries and has arrangements for the care of infants delivered preterm);
        - Level III Neonatal Intensive Care (NICU) services;
        - Pediatric services;
        - Trauma services;
        - Burn services; and
        - Nurseries

    iii. One (1) tertiary hospital either recognized as a Children's Hospital that meets the CMS definition in 42 CFR, Parts 412 and 413.
    iv. Tertiary care is defined as health services provided by highly specialized providers, such as medical sub-specialists and these services frequently require complex technological and support facilities.
    v. Rehabilitation Facilities.

b. LHCC will contract with out-of-state hospitals to comply with these requirements if there are no hospitals within the State that meet these requirements or a contract cannot be negotiated.

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- **Other Service Providers** – LHCC shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.

- ***Direct Access to Women's Health.*** Female members, including adolescents, will have direct access to an OB/GYN within the Plan's network for routine OB/GYN services regardless of whether their PCP (general practitioner, family practitioner or internist) provides such women's health services, including routine gynecological exams. In accordance with federal law, LHCC covers family planning services provided by any qualified Medicaid provider regardless of network participation without requiring a referral or authorization. The MCO shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in the RFP.

- ***Second Opinion.*** A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion will be granted to a network practitioner or an out-of-network practitioner, if there is no in-network practitioner available. The second opinion will be provided at no cost to the member.

- ***Out-Of-Network Services.*** If a member requires services that are not available from a qualified network practitioner, the decision to authorize use of an out-of-network practitioner will be based on continuity of care, availability and location of an in-network practitioner of the same

specialty and expertise, and complexity of the case. Network practitioners are prohibited from making referrals for designated health services to health care entities with which the practitioner or a member of the practitioner's family has a financial relationship.

- ***Cultural Diversity.*** LHCC collects cultural, ethnic, racial and linguistic data about practitioners on a voluntary basis during the credentialing process. Member data regarding ethnic, racial and linguistic data is obtained from data provided by its State enrollment entity and data collected voluntarily through member contacts and outreach efforts. LHCC will facilitate linking of members with practitioners who can meet members' cultural, ethnic, racial and linguistic needs and preferences.

Timely Access Exceptions. If no provider type (hospital, specialist, etc.) is available within the time/distance requirement of a member's residence, LHCC may request an exception for timely access on the basis of community standards. Such exceptions must be justified, documented, and submitted to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network Provider Development Management Plan.

If termination is related to network access, LHCC shall include in the notification to LDH their plans to notify members of such change and strategy to ensure timely access to members through out-of-network providers. If termination is related to the MCO's operations, the notification shall include LHCC's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers. LA.PRVR.23 outlines termination of providers and LA.MBRS.27 shall outline notification of members.

Gap Analysis and Intervention. LHCC analyzes its network adequacy on a quarterly basis by running Geo Access Maps for all contracted PCPs (Pediatricians, FPs, IMs, and NPs), Specialists (for the specialty types listed above), key ancillary services, and Hospitals. LHCC will provide GEO Access mapping and coding of all network providers during Readiness Review and quarterly thereafter or upon significant change in network. The Geo Access

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reports shall be consistent with the provider registry file sent to the enrollment broker. A network attestation shall be included with each Geo Access filing. LHCC shall provide analysis to show provider-to-member ratios as outlined in the Provider Network Companion Guide. LHCC shall ensure a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. The MCO report on accessibility shall include assessment of coverage including distance, population density and provider availability variables. All gaps in coverage will be identified and addressed in the Network Development and Management Plan.

At least annually, LHCC evaluates network cultural competency, network adequacy and appointment availability. The assessment is reported to the Quality Improvement Committee (QIC) at the individual practitioner, physician network, and/or medical group levels and/or as an aggregate as appropriate by provider type at least annually, although interim quarterly reports may also be reported to the QIC. The QIC, or designated subcommittee, will review the information for opportunities for improvement. Analysis of data will include comparison of results against the standard and analysis of the causes of any deficiencies (if appropriate) that must go beyond data display or simple reporting of results.

In the event that these reports uncover any network deficiencies, including those related to cultural competency, LHCC implements the network gap strategy described below. Intermediate short-term interventions are utilized when a network gap occurs and a member needs prompt access to specific services. In this situation:

Medical management, in conjunction with contracting, identifies the nearest non-contracted provider and authorizes out-of-network services.
In the event that the member requires covered services from a specific provider type or specialty that is not within the travel standard, the Utilization Management Department will authorize medically necessary covered services by an out-of-network provider until a suitable network provider is available. Single case agreements will be negotiated by network management staff and inquiries will be made to determine if the provider is open to a contractual relationship.

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LHCC will conduct an annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include the following aspects:

- Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services;
- Specialized behavioral health services needs of members; and
- Growth trends in eligibility and enrollment, including:
    - Current and anticipated numbers of Title XIX and Title XXI eligible; and
    - Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with LDH goals and principles.

The accessibility of services assessment will include:

- The number of current qualified specialized behavioral health service providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible;
- The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation;
- Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and
- Any service access standards detailed in a SPA or waiver.

Long term network gap solutions involve additional recruitment strategies. These include:

1. Approaching PCPs and other providers with limited or closed panels, and request that they open their panels to new members or members (or if applicable, to a relative of a member already in their panel). For PCPs, this would only apply if the PCP was still below 2,500 members for all MCOs plus LDH combined.

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2. Network specialists are approached to see if they can expand the number of members they will serve or their scope of services. Identifying potential providers through sources such as listing from the local medical societies and provider associations, case managers, Member Connections representatives, the Provider Advisory Council, established community relationships, Internet resources and personal recommendations from network providers in the area.

3. Utilizing listings of newly-licensed providers and state reports of providers issued new NPI numbers.

4. Monitoring non-par providers to assess whether they are reasonably anticipated to provide services at LHCC's request more than 25 times during the contract year, and

5. Maintaining relationships with providers who have declined to join the network.

6. Identifying sources of provider dissatisfaction and strengthening retention strategies.

Effectiveness of interventions are measured and reported at least annually in the QI Program evaluation. LHCC will submit an evaluation of NPD&MP at end of first year and annually thereafter.

The results of the reports and surveys described above will be used collectively by the Network Management and Contracting Department to assess the need for additional provider recruitment and by the Provider Relations Department to identify providers who may need education and/or corrective action plans to bring them into compliance with the health plan's accessibility standards.

The results of the reports will also be shared with LDH as well as with the health plan's senior management team and other regulatory bodies internal and external to the health plan as may be required and appropriate.

LHCC will develop and maintain a Network Provider Development and Management Plan (See LA.CONT.05) that will be continuously updated to assure network adequacy.

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REFERENCES:
LA.CONT.05
LA.PRVR.23
LA.MBRS.27
42 CFR §438.206, §438.208, §431.51
Title XIX and Title XXI
RFP 7.2
Provider Network Companion Guide

ATTACHMENTS:

AppendixSS_ProviderNetworkAppointment

Provider Network Companion Guide

DEFINITIONS:

***Affiliated Provider*:** A physician, hospital, group practice, nursing home, or ancillary medical service entity that has entered into a contract with LHC to provide health care services to LHCC's enrollees.

Covered Services: The health care services defined and covered under the agreement between LDH and LHCC.

Availability: **The extent to which the Plan provides the appropriate types and numbers of providers necessary to meet the needs of its members within defined geographical areas.**

Primary Care Physician (PCP): **a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices is responsible for providing all required Primary Care Services to Members. A PCP shall include general/family practitioners, pediatricians, internists, physician's assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with the Plan's contract provisions and licensure requirements.**

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Behavioral Health Specialists: **Psychiatrist, Psychologist, or Licensed Master Social Worker, Advanced Clinical Practitioner, (LMSW-ACP), Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT).**
High Volume Specialists: **With the exception of Behavioral Health Specialists, are defined by the Plan and may be based on claims volume (i.e net claim dollars).**

REVISION LOG

REVISION	DATE
• Changes-Added RFP appendix TT to process as attachment, RFP requirement adherence language, product attachment, specialist ratio language, lab/rad/hemodialysis/pharmacy/other providers time and distance changes, added language tying provider registry file, GEO access, and appendix UU. • RFP requirements – 7.1.3; 7.1.5; 7.3; 7.4; 7.5; 7.6.3.2; 7.8.3.2; 7.8.4; 7.8.5; 7.8.6; 7.8.8; 7.9.3; 7.9.4; 7.13.10;	11/2014
• Added to VII section II - available 24 hours per day • Added to VII section IV - Tertiary care is defined as health services provided by highly specialized providers, such as medical sub-specialists and these services frequently require complex technological and support facilities.	2/2015
• RFP requirements – 7.2.1; 7.3.7 • Added appendix SS and UU	7/2015
• RFP requirements – 7.3.7 • Changed DHH to LDH	7/2016
• RFP requirements – 7.1.	11/2016
• Formatting edits; Appointment Standards updated per RFP requirements Section 7.2	06/2017
• Grammatical and formatting edits	06/2018

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• Revised RFP Amendment 11 requirements – 7.3.7 • Revised all member ratio references/geographic criteria per LDH Provider Network Companion Guide; this replaces previous requirements set forth in Appendix SS and UU and Attachment TT	
• Inserted new RFP requirements (7.5.3.2, 7.8.6.1)	05/2019
• **Formatting edits and inserted NCQA criteria for high-volume & high-impact practitioners**	**01/2020**

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to a physical signature.

V.P., Network Development:_____Approval of file_____