LOUISIANA DEPARTMENT OF HEALTH
ACCESS REVIEW MONITORING FRAMEWORK

The Louisiana Department of Health (LDH) assumes the responsibility and accountability for the assessment of the adequacy of provider access to the state's Medicaid population. The Department's philosophy is to operate the Medicaid program in a manner that achieves the triple aim of optimizing health system performance by:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of healthcare.

LDH recognizes the importance of adequate access to medical providers and will continue to place provider access monitoring and maintenance as one of its highest priorities. Contracts with the managed care health plans require them to maintain minimum ratios of specialty physicians to enrollees, and both plan types must meet primary care provider (PCP) ratios. The Department conducts ongoing monitoring of the number of contracted providers in each health plan and requires plans to submit geo-spatial analyses with provider locations. The Department receives the total number of contracted providers for each health plan through weekly provider network registries submitted by the plans. Network development and areas for additional focus are standing topics for discussion at quarterly business reviews between the Department and the health plans. Since the inception of managed care, the Department has held quarterly meetings with each health plan's leadership individually for the purpose of reviewing overall performance and outcomes, and to identify opportunities for improvement and any needed adjustments.

LDH Medicaid beneficiaries are enrolled in managed care entities (MCEs) in larger numbers than fee-for-service (FFS) Medicaid. Effective June 2016, MCE plans had approximately 1.7 million enrollees. Accordingly, it is imperative that a predominant focus is on the MCE practices and provider directories.

The history of the vast shift to MCEs is relatively recent. The first contract period, began in 2012, included two primary care case management entities, referred to as shared savings health plans, and three full-risk managed care organizations (MCOs), called prepaid health plans, and ended January 31, 2015. Also occurring at that time behavior health services were being managed under a separate contract, by a single Prepaid Inpatient Health Plan (PIHP). In 2014, LDH published a Request for Proposals (RFP) seeking proposals and bids from MCOs with an interest in serving Louisiana Medicaid beneficiaries on a fully capitated payment basis. The RFP (contract) had a February 2015 inception date. Ultimately, five MCOs were contracted for the managed care activities: Aetna Better Health of Louisiana (Aetna), Amerigroup Louisiana, Inc. (AMG), AmeriHealth Caritas Louisiana (ACLA), Louisiana Healthcare Connections (LHC) and United

Healthcare Community Plan (UHC). LDH contracted with a Prepaid Ambulatory Health Plan (PAHP) during this year as well to provide dental services for its Medicaid and CHIP population. In December 2015, LDH integrated Behavioral Health (BH) services into these five MCOs, except for Coordinated System of Care (CSoC) services, which remain with this PIHP. The collective effort of the MCOs, PIHP, PAHP, and LDH is the Healthy Louisiana Program (formerly known as "Bayou Health"). Hereinafter, all managed care providers will be referred to collectively as MCEs.

MCE PROVIDER NETWORKS

As an MCE, each plan develops and maintains its own provider network and reports periodically (and upon request as ad-hoc reporting) to LDH on the following:

- The content of the MCE provider Directory;
- Encounter and Utilization Data;
- Claims Data;
- Credentialing activity;
- Provider access mapping; and
- Other ad-hoc reporting.

LDH fully assumes the role of oversight of the seven MCEs that currently administer the Healthy Louisiana Program.

OVERALL OVERSIGHT RESPONSIBILITIES

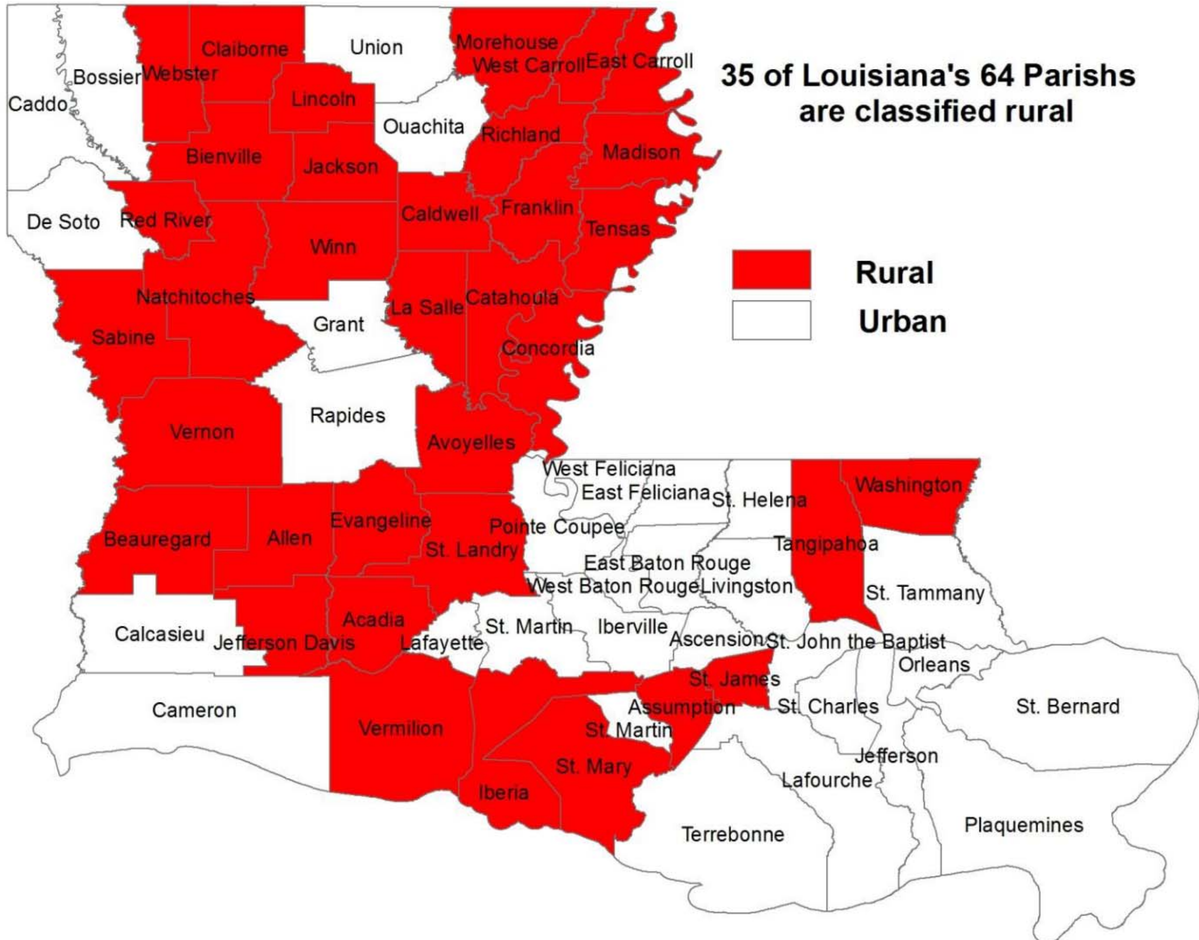
LDH recognizes several distinct provider lines upon which focus should be made:

- Primary Care (including physicians, federally qualified health centers (FQHCs) and dental care);
- Physician Specialty services;
- Behavioral Health;
- Pre-natal and Post-natal services;
- Home Health; and
- Retail pharmacy network.

LOUISIANA STATE GEOGRAPHY AND PROVIDER MEASUREMENT

Louisiana is a coastal plains state comprised of 64 parishes (county equivalents). For purposes of access analysis, 35 of those 64 parishes are classified as rural and those classifications control the access classifications.

Louisiana Rural Parishes Map



Medicaid Quality Management, Statistics and Reporting **Date: 5/8/2014**

CURRENT AND CONTINUING STANDARDS FOR ACCESS

LDH publishes its standards for network adequacy and access standards in the aforementioned MCE contracts, contract appendices SS, TT and UU. The access standards appendices are outlined below.

Appendices SS, TT and UU follow. These appendices provide standards for appointment.

Appendix SS

Provider Network - Appointment Availability Standards

Emergencies and Urgent Care	Standard	Monitoring
Emergency Care	24 hours, 7 days/week	CAHPS Survey, Complaint Analysis
Urgent Non-emergency Care	24 hours, 7 days/week	
Primary Care	**Standard**	**Monitoring**
Non-Urgent Sick	72 hours	CAHPS Survey, Complaint Analysis
Non-Urgent Routine	6 weeks	
After Hours, by phone	Answer by live person or call-back from a designated medical practitioner within 30 minutes	Survey, Complaint Analysis
Prenatal Visits	**Standard**	**Monitoring**
1st Trimester	14 days	CAHPS Survey, Complaint Analysis
2nd Trimester	7 days	
3rd Trimester	3 days	
High risk pregnancy, any trimester	3 days	
Specialty Care	**Standard**	**Monitoring**
Specialist Appointment	1 month	Complaint Analysis, Mystery Shopper, EQRO Survey
Waiting Room Time	**Standard**	**Monitoring**
Scheduled Appointments	<45 minutes	Complaint Analysis
Accepting New Patients	**Standard**	**Monitoring**
The practitioner office is open to new patients	Provider is listed in directory and/or registry file as open	EQRO Survey, Mystery Shopper, Complaint Analysis

Appendix TT
Network Providers by Specialty Type

Specialty	LA Medicaid Provider Specialty	NPPES Taxonomy Code	Specialty	LA Medicaid Provider Specialty	NPPES Taxonomy Code
PRIMARY CARE PROVIDERS			SPECIALISTS (continued)		
Family Practice	08	207Q00000X	Internal Medicine	41	207R00000X
FQHCs	42	261QF0400X	Licensed Clinical Social Worker	73	1041C0700X
General Practice	01	208D00000X	Maternal & Fetal Medicine	3C	207VM0101X
Internal Medicine PCPs	41	207R00000X	Med Supply / Certified Orthotist	51	222Z00000X
Nurse Practitioners	79	363L00000X	Med Supply / Certified Prosthetist	52	224P00000X
OB/GYN PCPs	16	207V00000X	Medical Oncology	2J	207RX0202X
Pediatrics	37	208000000X	Neonatal Perinatal Medicine	1C	2080N0001X
Rural Health Clinics	94	261QR1300X	Nephrology	39	207RN0300X
ANCILLARY SERVICES			Nephrology	2K	207RN0300X
Ambulance Service Supplier	59	341600000X	Neurological Surgery	14	207T00000X
Dialysis Centers	n/a	261QE0700X	Neurology	13	2084N0400X
Durable Medical Equipment	n/a	332B00000X	Nuclear Medicine	2Q	207UN0903X
Home Health	n/a	251E00000X	Nurse Practitioner	79	363L00000X
Infusion Therapy	n/a	261QE0700X	OB/GYN	16	207V00000X
NEMT - Non-profit	45	343900000X	Occupational Therapy	74	225X00000X
NEMT - Profit	46	343900000X	Ophthalmology	18	207W00000X
Urgent Care Clinics	7N	261QU0200X	Optician / Optometrist	88	156FX1800X
HOSPITALS			Orthodontist	19	1223X0400X
Hospitals- General Acute Care	86	282N00000X	Orthopedic Surgery	20	207X00000X
Hospitals- Children's	86	282NC2000X	Otology, Laryngology, Rhinology	04	207W00000X
Hospital- Rehabilitation	86	283X00000X	Pathology	22	207ZP0102X
PHARMACIES			Pediatric Cardiology	1D	2080P0202X
Pharmacies	n/a	333600000X	Pediatric Critical Care Medicine	1E	2080P0203X
Specialty			Pediatric Day Health Care	1Z	261QM3000X
Adolescent Medicine	1A	2080A0000X	Pediatric Emergency Medicine	1F	2080P0204X
Allergy	03	207K00000X	Pediatric Endocrinology	1G	2080P0205X
Anesthesiology	05	207L00000X	Pediatric Gastroenterology	1H	2080P0206X
Audiologist	64	231H00000X	Pediatric Hematology - Oncology	1I	2080P0207X
Cardiac Electrophysiology	2A	207RC0001X	Pediatric Infectious Disease	1J	2080P0208X
Cardiovascular Disease	06	207RC0000X	Pediatric Nephrology	1K	2080P0210X
Cardiovascular Disease	2B	207RC0000X	Pediatric Pulmonology	1L	2080P0214X
Chiropractor	35	111N00000X	Pediatric Rheumatology	1M	2080P0216X
Clinic or Other Group Practice	70	261QM1300X	Pediatric Sports Medicine	1N	2080S0010X
Critical Care Medicine	2C	207RC0200X	Pediatric Surgery	1P	2086S0120X
Critical Care Medicine	3A	207RC0200X	Pediatrics	37	208000000X
Dermatology	07	207N00000X	Physical Medicine Rehabilitation	25	208100000X
Diagnostic Laboratory	72	293D00000X	Physician Assistant	2R	363A00000X
Emergency Medicine	1T	207P00000X	Plastic Surgery	24	208200000X
Endocrinology & Metabolism	2E	207RE0101X	Podiatric Surgery	48	213ES0131X
Family Practice	08	207Q00000X	Proctology	28	208C00000X
Gastroenterology	10	207RG0100X	Psychiatry	26	2084P0800X
Gastroenterology	2F	207RG0100X	Pulmonary Disease	2L	207RP1001X
General Practice	01	208D00000X	Pulmonary Diseases	29	207RP1001X
General Surgery	02	208600000X	Radiology	30	2085R0202X
Geriatric Medicine	2G	207RG0300X	Rheumatology	2M	207RR0500X
Geriatrics	38	207RG0300X	Rural Health Clinic	94	261QR1300X
Gynecologic oncology	3B	207VX0201X	Speech Therapy	71	235Z00000X
Hand Surgery	40	2086S0105X	Surgery - Critical Care	2N	2086S0102X
Hematology	2H	207RH0000X	Surgery - General Vascular	2P	2086S0129X
Independent Laboratory	69	291U00000X	Thoracic Surgery	33	208G00000X
Indiv Certified Prosthetist - Ortho	57	225000000X	Urology	34	208800000X
Infectious Disease	2I	207RI0200X			

Appendix UU

Provider Network - Geographic and Capacity standards

Primary Care	Provider:Patients	Rural	Urban	Monitoring
Physicians	1:2500			Quarterly GeoAccess Reports, Weekly Provider Registry
Physician Extenders	1:1000	30 miles	20 miles	
Hospitals	**Provider:Patients**	**Rural**	**Urban**	**Monitoring**
Acute Inpatient Hospitals		30 miles	20 miles	Quarterly GeoAccess Reports, Weekly Provider Registry
Ancillary				
Lab		30 miles	20 miles	Quarterly GeoAccess Reports, Weekly Provider Registry
Dialysis Centers		30 miles	10 miles	
Radiology		30 miles	20 miles	
Specialists				
Allergy/Immunology	1:100,000	60 miles for 75% of members 90 miles for 100% of members		Quarterly GeoAccess Reports, Weekly Provider Registry
Anesthesiology				
Audiology				
Cardiology	1:20,000			
Chiropractic				
Dermatology	1:40,000			
Emergency Medical				
Endocrinology and Metabolism	1:25,000			
Gastroenterology	1:30,000			
Hematology/Oncology	1:80,000			
Infectious Diseases				
Neonatology				
Nephrology	1:50,000			
Neurology	1:35,000			
Nuclear Medicine				
OB/GYN				
Occupational Therapy				
Ophthalmology	1:20,000			
Optician/Optometry				
Orthopedics	1:15,000			
Otorhinolaryngology/Otolaryngology	1:30,000			
Pathology				
Pediatric Allergy				
Pediatric Cardiology				
Pediatric Critical Care Medicine				
Pediatric Emergency Medicine				
Pediatric Endocrinology				
Pediatric Gastroenterology				
Pediatric Hematology - Oncology				
Pediatric Infectious Disease				
Pediatric Nephrology				
Pediatric Pulmonology				
Pediatric Rheumatology				
Pediatric Sports Medicine				
Pediatric Surgery				
Physical Therapy				
Podiatry				
Pulmonary Medicine				
Radiology - Diagnostic				
Radiology -Therapeutic				
Rheumatology				
Speech Therapy				
Surgery - Cardiovascular				
Surgery - Colon and Rectal				
Surgery - General				
Surgery - Neurological				
Surgery - Pediatric				
Surgery - Plastic				
Surgery - Thoracic				
Urology	1:30,000			

Appendix UU

Behavioral Health Provider Network - Geographic and Capacity standards

			Monitoring
Psychiatrists	**Rural**	**Urban**	Quarterly GeoAccess Reports, Network Development Plan, Weekly Provider Registry
Psychiatrists	**30 miles**	**15 miles**	
Behavioral Health Specialists	**30 miles**	**15 miles**	
Advanced Practice Registered Nurse (Behavioral Health Specialty)	The network standard is applied to this category of providers collectively. However, DHH requires reporting and monitoring for each individual specialist type shown here.		
Clinical Nurse Specialist (Behavioral Health Specialty)			
Licensed Addiction Counselor			
Licensed Clinical Social Worker			
Licensed Marriage and Family Therapist			
Licensed Professional Counselor			
Medical Psychologist			
Physician Assistant(Behavioral Health Specialty)			
Psychologist-Clinical			
Psychologist-Counseling			
Psychologist-Developmental			
Psychologist-General (Non-Declared)			
Pychologist-Other			
Psychologist-School			
Psychiatric Residential Treatment Facilities (PRTFs)	**Travel distance to a PRTF shall not exceed 200 miles for 90% of members**		
Psychiatric Residential Treatment Facility			
Psychiatric Residential Treatment Facility Addiction			
Psychiatric Residential Treatment Facility Hospital Based			
Psychiatric Residential Treatment Facility Other Specialization			
Substance Use Residential Treatment Facilities	**Adolescents**	**Adults**	
ASAM Level III.3/5 Clinically Managed High Intensity	**60 miles**	**30 miles**	
ASAM Level III.7 Medically Monitored Intensive	**n/a**	**60 miles**	
ASAM Level III.7D Medically Monitored Re	**n/a**	**60 miles**	
Other Facilities	**n/a**	**n/a**	
Crisis Receiving Center	The network development plan must include an assessment of coverage for access to these services including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan		
Repite Care Services Agency/Center Based Respite			
Assertive Community Treatment Team			
Mental Health Clinic (Legacy MHC)			
Behavioral Health Rehab Provider Agency			
Mental Health Rehabilitation Agency			
Multi-Systemic Theraphy Agency			
Therapeutic Group Home			
Mental Health Clinic (Legacy MHC)			
Hospital, Distinct Part Psychiatric Unit			
Hospital, Free Standing Psychiatric Unit			
Federally Qualified Health Clinics (with Behavioral Health Specialty)			
Substance Abuse and Alcohol Abuse Center (Outpatient)			

LDH reviews all provider-related reports to ensure that the standards outlined in the pronouncements are realized. Should the standards not be met, LDH will work with the MCE(s) to correct whatever deficiencies might exist. LDH can issue Health Plan Advisories (HPAs) and Informational Bulletins (IBs) to clarify issues and directives when necessary. LDH also creates corrective plans, or may impose financial penalties where violations are serious or particularly durable in duration.

MULTIPLE MCO DATA-AGGREGATION

In the course of analyzing physician:patient ratios, it is necessary to analyze aggregate MCE data to determine the true physician:patient capacity for the overall population where there are providers common to multiple MCEs. For example, looking at patient assignments from a single MCO is insufficient to adequately monitor practice limit ratios. In such a case, it is necessary to look at the collective impact of all MCO patient assignments in order to get a true impact of a provider's availability. Accordingly, LDH will ensure that the provider registry will be reviewed every 30 days to ensure that the multiple MCE data aggregation is accomplished and reviewed.

IMPACT OF REIMBURSEMENT CHANGES

Reimbursement reductions can significantly impact the willingness of providers to participate in MCE networks. When reimbursement rates are reduced significantly, there can be a corresponding reduction in the number of providers who will accept Medicaid patients. Therefore, it is imperative that LDH carefully monitor the aggregate provider movement in or out of managed care with changes in reimbursement. LDH shall endeavor to track the elasticity of the supply of providers in response to reimbursement changes. LDH will establish a baseline index of providers and use that baseline to monitor changes in the various directories of the MCEs.

Beyond the number of providers who are willing to accept Medicaid patients in the main are those who might curtail the treatment of enrollees in manners that are constructive reductions in the number of patients seen. For instance, providers might choose to engage in any of the following practices:

- Limit the sites at which Medicaid patients will be seen (in multi-site providers);
- Limit the days on which Medicaid patients are welcome;
- Limit the age(s) of the patients that will be seen;
- Limit the access to existing Medicaid patients;
- Reduce the number of MCOs with which the provider is contracted; or
- Significantly increase the request-to-appointment time lag to see patients.

LDH will consider all these factors when assessing the provider participation index of provider supply elasticity.

SIGNIFICANT CHANGES IN BENEFICIARIES

MCE enrollment is not static. Changes in enrollment might occur at any time and quite dramatically. A relevant example is Medicaid expansion* where the served population increases markedly. The following table is an example of expansion activity on and as of September 27, 2016. The Table illustrates the significant rate of growth of the Expansion population.

Metric	9/27/2016
New Adult Group Members	
Total # Members Enrolled	312,322
Total # of Pending Applications in 50-550	461
FFM Decisions and Referrals	
# of Decisions	101
# of Referrals	20
# of Adult Group Decisions	74
# of Adult Group Referrals	0
# Adult Group Referrals Approved	0
# Adult Group Referrals Denied	0
# Adult Group Referrals Pending	11
Health Plan Enrollment for New Adult Group	
Aetna	68
AmeriHealth Caritas	66
Amerigroup	357
LA Healthcare Connections	453
United HealthCare Community Plan	296
Total	1,240

*Louisiana's decision to expand Medicaid provides a profound illustration. Beginning in June/July of 2016, LDH's expansion population has grown to over 300,000 beneficiaries in a three-month period. Significant changes in population such as this may affect the willingness of providers to join or stay in networks in profound ways:

- Additional members might create an incentive for joining a network where a provider might have previously viewed the population as too sparse to sustain a practice that relies heavily on Medicaid.

- Additional members could create circumstances that cause providers' maximum patient threshold to be crossed, thereby causing denials for the members.
- Particular providers might prefer a smaller Medicaid population.

In addition to the decisions of particular providers, the mass addition of enrollees can instantly upset long-set physician: patient ratio balances. Therefore, mass additions of beneficiaries must be carefully monitored.

LDH shall carefully note and address any circumstances in which members are added or deleted in significant volumes.

COMPLAINTS AND OTHER OBSERVATIONS

LDH does not exclusively rely on self-reporting by the MCEs to monitor access to care. Among the other sources to which LDH shall have resort are sources such as stakeholder complaints and encounter data.

LDH conducts surveys and other measures of member and provider satisfaction and concerns and will continue to engage in such surveys to glean information about potential sources of provider satisfaction.

LDH consistently meets with, and receives data from, provider and enrollee interest groups, including reviewing complaints from legislators and community groups. All complaints that might indicate problems with either network adequacy or directory accuracy are explored. Any negative issues are immediately reported to the MCE(s) and followed up.

CHANGES IN DISTANCE BY NON-EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

LDH receives regular reporting from non-emergency medical transportation (NEMT) providers. These reports can be analyzed for periodic changes in aggregate and per-trip distances travelled to provider sites. Notable changes in distance and frequency can evince a change in access.

ANALYSIS OF CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

LDH regularly reviews reports of payments to out-of-network providers. A regularly- reviewed report will be that of the Claims Paid to Out-of-Network (OON) Providers. Claims paid to out-of-network providers are indicative of a potential shortage of particular provider types in an MCO's network. Where an MCO has an unusually high number of payments to OON providers, LDH will investigate those instances with the goal of determining the reason(s) for the OON payments. OON payments are almost always the results of case agreements in cases of provider network deficiencies.

OTHER ANALYSES

Encounter data is an important indicator of network adequacy. With the state's Medicaid population at nearly 1.7 million recipients post-expansion, the regular encounter data is an important and rich source of data from which information about directory accuracy can be gleaned.

As an example, where a provider is listed as in-network, ("par") and no encounter data is evidenced for a significant reporting period for that provider, it is presumed that the provider listing needs additional focus. In such a case, LDH will focus heavily on that listed provider and employ investigations that begin with mystery-calls as a first step. Outliers/findings will be addressed with the MCO(s) and any findings of intentionally listing ineligible providers will be subject to any sanctions available under the MCO contract.

While random mystery calling is useful, using the encounter data can serve as an important tool to cull the population of mystery-call targets to manageable numbers.

MEASURES OF REIMBURSEMENT ADEQUACY AND COMPARISON TO KNOWN-VALUE PLANS

LDH recognizes the benefits of comparing the efficiency and reimbursement of plans that have a public and transparent cost. Public employees' health plans are often cited as an excellent source of such data. The State of Louisiana, Office of Group Benefits (OGB) is an example of such a plan.

OGB provides healthcare to about 240,000 members (including dependents) and the membership is very stable in comparison to many commercial insurance plans. OGB has a multi-tiered retirement employer contribution protocol that rewards retirees with greater employer premium contributions in exchange for greater years of voluntary participation. This

protocol creates an incentive for employees to join and remain in the plan, leading to a high degree of membership stability. The demographic age distribution in the plan is newborn-through-retiree, with most retirees above the age of 65 having Medicare as the primary payer. Because the preponderance of those over 65 have Medicare, the data is fairly easy to compare to the Louisiana Medicaid population by excluding those who have a Medicare-primary indicator.

OGB benefits are administered by Blue Cross and Blue Shield of Louisiana for the preponderance of the OGB members. Data on OGB PMPM and other spend are regularly made public for its periodic Policy Board and other legislatively-required reports. While data are not available for specific provider payout, aggregate data on overall spend is available.

SUMMARY

LDH has a profound interest in ensuring that the provider networks of MCEs are adequate and that the directories purporting to delineate the providers are accurate. LDH will continue to monitor the issues of access and accuracy in the manner outlined and will enhance and augment efforts as resources and methods become feasible.