

Rule No. 560-X-64.XX Service Delivery Network Requirements for Integrated Care Networks

(1) Definitions - As referenced in this Chapter of the Alabama Medicaid Administrative Code the following terms shall be defined as follows:

(a) *Primary medical provider* (PMP) is defined as one of the following:

- (i) Family Practitioner
- (ii) Federally Qualified Health Center
- (iii) General Practitioner
- (iv) Internist
- (v) Geriatrician
- (vi) Obstetrician or Gynecologist
- (vii) Pediatrician
- (viii) Rural Health Clinic

(b) *Core Specialist* is defined as each of the following:

- (i) Anesthesiologist
- (ii) Cardiologist
- (iii) Cardiovascular Surgeon
- (iv) Endocrinologist
- (v) Gastroenterologist
- (vi) General Surgeon
- (vii) Nephrologist
- (viii) Neurologist
- (ix) Oncologist
- (x) Ophthalmologist
- (xi) Optometrist
- (xii) Orthopedic surgeon
- (xiii) Psychiatrist
- (xiv) Pulmonologist
- (xv) Rheumatologist
- (xvi) Urologist

(c) *Facility* is defined as each of the following:

- (i) Hospitals as defined in Rule 560-X-7-.02
- (ii) Psychiatric Facilities for Individuals 65 and Over
- (iii) Outpatient Mental Health Center
- (iv) Nursing Facility as defined in Rule 560-X-10-.01

(d) *Hospice Provider* is defined in accordance with Rule 560-X-51-.02(1) and which meets the requirements in Rule 560-X-51-.03.

(e) *Home and Community Based Service – Site-Based Services Provider* is defined as a provider of a 1915(c) waiver approved service to whom an enrollee must travel, in order to receive services.

(f) *Home and Community Based Service – In-Home Services Provider* is defined as a provider of a 1915(c) waiver approved service who travels to an enrollee’s home, in order to provide services.

(g) *Non-Core Specialist* is defined as any medical provider type not listed above which is needed to appropriately service the Integrated Care Network (“ICN”) enrollees and provide care delivery for all of the services and benefits covered by the ICN program.

(h) *Urban and Rural Counties* are defined in accordance with the Code of Federal Regulations 42 C.F.R. § 438.52(b)(3), which defines a rural area as any county designated as “micro,” “rural,” or “County with Extreme Access Considerations (CEAC)” in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year.

(i) *Service Delivery Network* is defined as one that meets and maintains each of the following:

(i) Makes available and accessible all non-excluded services that are required under the State Plan and 1915(c) waiver(s) included in the ICN program, including those Covered Services identified by rule in the Alabama Medicaid Administrative Code and in the risk contract between the Medicaid Agency and the ICN.

(ii) Consists of a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all enrollees of the ICN. The following factors shall be considered in determining an appropriate provider network.

(A) The anticipated Medicaid enrollment in accordance with the state's standards for access to care;

(B) The expected utilization of services, taking into account the characteristics and health care needs of specific Medicaid populations represented in the particular ICN;

(C) The numbers and types of providers (in terms of training, experience, and specialization) required to furnish the contracted Medicaid services;

(D) The number of network providers who are not accepting new Medicaid patients;

(E) The geographic location of providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees;

(F) The ability of Home and Community Based Service – In-Home Services Providers to provide in-home services outside of standard business hours, defined as Monday-Friday (excluding legal holidays), from 8AM to 5PM;

- (G) The ability of network providers to communicate with limited English proficient enrollees in their preferred language;
- (H) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities;
- (I) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions;
- (J) The ability of network providers to provide the delivery of services in a culturally competent manner to all Medicaid enrollees in accordance with 42 C.F.R. § 438.206(c)(2).
- (K) The ability of network providers to offer self-directed service options for enrollees who wish to self-direct eligible services, as defined by an approved 1915(j) waiver.
- (iii) Provides female enrollees with direct access to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventive health care services.
- (iv) Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
- (v) Meets and requires its providers to meet the following state standards for timely access to care and services, taking into account the urgency of the need for services:

Appointment Availability	
Office Appointments	
Life-Threatening Emergency Care	Immediate
Urgent Care	24 hours
Routine Sick Care – PMP	3 calendar days of presentation or notification excluding legal holidays
Routine Sick Care – Core Specialist	30 calendar days of presentation or notification excluding legal holidays
Routine Well Care	90 calendar days (15 calendar days if pregnant)
Behavioral Health Services	
Non-Life-Threatening Emergency	6 hours
Urgent Care	48 hours
Routine Visits	30 calendar days
Phone Access	24 hours
Appointment with behavioral health provider following a discharge from hospital	72 hours
Wait Times	
Office-based Appointments	

Walk-Ins	2 hours or schedule an appointment within the standards of appointment availability
Scheduled Appointment	1 hour
Life-Threatening Emergency	Immediate
Home and Community Based Services	
Site-Based Services	No greater than 1-hour difference between enrollee arrival and departure as scheduled and documented in the enrollee's person centered service plan.
In-Home Services	No greater than 1-hour difference between delivery of the service as scheduled and documented in the enrollee's person centered service plan.
Transportation Services	
Non-Emergency Transportation Services	Transportation scheduled so that the enrollee arrives on time for the appointment, but no sooner than 1 hour before the appointment; and no greater than 1 hour wait after the conclusion of the appointment for transportation home; and not be picked up prior to the completion of the appointment.

(vi) Establishes appropriate policies and procedures to regularly monitor providers and ensure compliance with the above listed accessibility standards. The policies and procedures shall require a correction action if there is a failure to comply.

(vii) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees. The network criteria ("Provider-Specific Network Criteria") are as follows:

Provider Type	Minimum Number	Distance
PMPs	1.5 per 1,000 non-dual eligible enrollees, with a minimum of two	50 miles from each non-dual eligible enrollee's residence
Core Specialists (for each of the types identified in section (1)(b) of this rule)	0.2 per 1,000 non-dual eligible enrollees	50 miles from each non-dual eligible enrollee's residence
Facilities (for each of the types identified in section (1)(c) of this rule) excluding Nursing Facilities as defined in Rule 560-X-10-.01	No requirement	50 miles from each enrollee's residence
Nursing Facilities as defined in Rule 560-X-10-.01	No requirement	25 miles from each enrollee's residence before entering the Nursing Facility who resides in an urban county, 50 miles from each enrollee's residence before entering the Nursing

		Facility who resides in a rural county
Hospice Provider as defined in Rule 560-X-51-.03 and which meets the requirements in Rule 560-X-51-.03	2 provider options per county	No requirement
Home and Community Based Service – Site-Based Services Provider (for the type identified in section (1)(e) of this rule)	2 provider options per county	25 miles from each enrollee’s primary community residence who resides in an urban county, 50 miles from each enrollee’s primary community residence who resides in a rural county
Home and Community Based Service – In-Home Services Provider (for type identified in section (1)(f) of this rule)	2 provider options per county	No requirement

The distance requirement for each provider type listed above is limited to 30 miles from the state line border for out-of-state providers.

(viii) Must have an adequate amount of Non-Core Specialists, as needed to appropriately service its enrollees and provide care delivery for all of the services and benefits covered by the ICN program.

(ix) Must have an adequate amount of Nursing Facilities as defined in Rule 560-X-10-.01, Hospice Providers as defined in Rule 560-X-51-.02(1) and which meet the requirements in Rule 560-X-51-.03, Home and Community Based Services – Site-Based Services Providers as defined in section (1)(e) of this rule, and Home and Community Based Services – In-Home Services Providers as defined in section (1)(f) of this rule, as required to appropriately service its enrollees, provide choice of providers to enrollees, and facilitate timely and effective care transitions and community participation.

(x) The ICN must establish agreements with the Alabama Department of Mental Health (ADMH) to ensure that each ICN establishes and maintains an adequate network of ADMH certified behavioral health providers to appropriately address the needs of enrollees who have mental illnesses and substance abuse disorders. The ICN provider network must include ADMH-certified mental health and substance abuse providers.

(xi) If the ICN’s network is unable to provide covered services under the contract to a particular enrollee, until such deficiency is remedied the ICN must adequately and timely cover these services out of network for the enrollee, for as long as the ICN is unable to provide them in network.

(xii) Requires out-of-network providers to coordinate with the ICN with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

(2) Each entity selected via competitive procurement must demonstrate to the satisfaction of the Medicaid Agency that its Service Delivery Network meets the requirements of this rule based on the timelines established by the Medicaid Agency. An exception from the requirements of Service Delivery Network requirements as defined in this rule may be made, within the sole discretion of the Medicaid Agency, upon the request of an entity using an Agency approved form, or as otherwise deemed appropriate by the Medicaid Agency.

(a) The ICN may request the Agency for an exception to a Provider-Specific Network Criteria which must be in writing and include, at a minimum:

(i) Description of the current provider-specific network standard;

(ii) The exception the ICN is requesting;

(iii) Steps taken by the ICN to comply with requirement before requesting the exception;

(iv) Description of the ICN's plan to become compliant with the Provider-Specific Network Criteria by the expiration of the exception, if granted; and,

(v) Description of the ICN's plan to adequately provide covered services if exception is granted.

(b) In addition to the information provided by the ICN and other relevant factors, the Agency will, at a minimum, take into consideration the number of providers in each provider specialty practicing in the State in evaluating a request for an exception from a Provider-Specific Network Criteria.

(c) If the Agency grants an exception, the ICN must submit quarterly reports to the Agency detailing enrollee access to the provider type subject to the exception.

(d) Any exception issued in accordance with this subsection will expire after one year, which may be renewed upon the ICN's request and in the Agency's sole discretion.

(e) An exception may be revoked earlier if the Agency determines, in its sole discretion, that the continuance of the exception is to the detriment of the enrollees or the circumstances have materially changed since the exception was granted.

(f) Each ICN must also submit documentation necessary to demonstrate that the ICN has the capacity to serve the expected enrollment in accordance with Medicaid standards for access to care under this rule at the time it enters into a full-risk contract with the Medicaid Agency and at any time there has been a significant change in the entity's operations that would affect capacity and services.

(3) Notwithstanding the minimum network requirements of this rule, Medicaid enrollees shall have the option to be treated at the nearest hospital or other facility able to provide the most appropriate

medically necessary level of care in cases of medical emergency or necessity and/or when the treatment of a Medicaid enrollee elsewhere could pose an unreasonable risk of harm. For the purposes of this Subsection, medical emergency or necessity is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. A medical emergency or necessity is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

(4) Each ICN must ensure compliance with all requirements for the furnishing of Medicaid services in accordance with this rule, applicable laws and medical standards as well as the needs of Medicaid enrollees.

(5) The Medicaid Agency may inspect or request additional documentation and information relating to the documentation submitted pursuant to this rule at any time to verify the information contained therein.

(6) Notwithstanding any provisions of this rule to the contrary, any ICN shall be governed by federal access standards which may be found in their entirety in 42 C.F.R. §§ 438.206 - 438.210 and which are hereby incorporated by reference and made a part of this rule as if set out in full and all provisions thereof are adopted as rules of the Medicaid Agency.

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Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq*; 42 C.F.R. § 438.68; 42 C.F.R. §§ 438.206 - 438.210.

History: Emergency rule filed and effective [DATE].