

## **Rule No. 560-X-62-.12 Service Delivery Network Requirements**

(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) Pediatrician
- (vi) Obstetrician or Gynecologist
- (vii) Rural Health Clinic

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

- (i) Allergist (for the purposes of this rule, an ENT or an Otolaryngologist will qualify as this specialist)
- (ii) Anesthesiologist
- (iii) Cardiologist
- (iv) Cardiovascular Surgeon
- (v) Dermatologist
- (vi) Gastroenterologist
- (vii) General Surgeon
- (viii) Neurologist
- (ix) Oncologist
- (x) Ophthalmologist
- (xi) Optometrist
- (xii) Orthopedic surgeon
- (xiii) Psychiatrist
- (xiv) Pulmonologist
- (xv) Radiologist
- (xvi) Urologist

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

- (i) Hospitals as defined in Rule 560-X-7-.02
- (ii) Inpatient Psychiatric Hospitals/Units
- (iii) Laboratory Services
- (iv) End Stage Renal Disease Treatment and Transplant Center
- (v) Outpatient Mental Health Center
- (vi) Independent Radiology Center

(d) *Non-Core Specialist* is defined as any medical provider type not listed above which is needed to appropriately service the regional care organization/alternate care provider (“RCO/ACP”) members and provide care delivery for all of the services and benefits covered by the RCO/ACP program.

(e) *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 to enrollees of the RCO/ACP.

(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 RCO/ACP. The following factors shall be considered in determining an appropriate provider network.

(A) The anticipated Medicaid enrollment in its service area 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 RCO/ACP;

(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;

(F) For rating periods for contracts with an RCO/ACP beginning on or after July 1, 2018:

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

(2) The ability of network providers to communicate with limited English proficient enrollees in their preferred language;

(3) 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;

(4) 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;

(5) 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). ~~Culturally appropriate care to ensure quality care outcomes for enrollees of diverse cultural backgrounds.~~

(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:

<b>Appointment Availability</b>	
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)
<b>Behavioral Health Services</b>	
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
<b>Office Wait Times</b>	
Walk-Ins	2 hours or schedule an appointment within the standards of appointment availability
Scheduled Appointment	1 hour
Life-Threatening Emergency	Immediate

(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) Must have an adequate amount of Non-Core Specialists as needed to appropriately service its members and provide care delivery for all of the services and benefits covered by the RCO/ACP program. These specialties are not required to be geographically located within the RCO's region.

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

Provider Type	Minimum Number	Distance
PMPs excluding Pediatricians and Delivering Healthcare Providers	1.5 per 1,000 enrollees, with a minimum of two	50 miles from each enrollee's residence
Core Specialists (for <b>each</b> of the types identified in section (1)(b) of this rule)	0.2 per 1,000 enrollees	50 miles from each enrollee's residence
Pediatricians	1.5 per 1,000 enrollees under the age of <del>19</del> <u>21</u> , with a minimum of two	50 miles from each enrollee's residence
Obstetricians and Gynecologists	No requirement	50 miles from each enrollee's residence
Facilities (for <b>each</b> of the types identified in section (1)(c) of this rule)	No requirement	50 miles from each enrollee's residence

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

(ix) Maintains a network to serve the region's newborn population in the following areas:

(A) Delivering ~~O~~bstetricians, gynecologists, or other physicians that have credentials to perform deliveries must have admitting privileges to a delivery hospital in the RCO/ACP's network.

(B) The RCO/ACP has access to an appropriate level neonatal intensive care unit (NICU). The NICU must be able to provide the appropriate level of medically necessary care for high-risk newborns. In regards to distance, the NICU must be at least one of the following:

- (1) the closest NICU to the delivering hospital;
- (2) the closest NICU to the newborn's mother's residence; or
- (3) the next closest NICU of either (1) or (2) above.

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

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

(xii) Requires out-of-network providers to coordinate with the RCO/ACP 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.

(xiii) For rating periods for contracts with an RCO/ACP beginning on or after July 1, 2018, provides sufficient family planning providers to ensure timely access to covered services.

(2) Each entity with probationary regional care certification must demonstrate to the satisfaction of the Medicaid Agency that its Service Delivery Network meets the requirements of this rule. 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) On or before February 1, 2015, each entity with probationary regional care organization certification must submit a status report to the Medicaid Agency demonstrating how it intends to establish an adequate medical service delivery network by April 1, 2015.

(b) Not later than April 1, 2015, each entity with probationary regional care organization certification must demonstrate to the Medicaid Agency's preliminary approval the ability, as evidenced by appropriate assurances and supporting documents, to establish a Service Delivery Network that meets the requirements of this rule.

(c) On or before ~~January 10, 2017~~February 28, 2017, or such later date as may be determined by the Medicaid Agency, each entity with probationary regional care organization certification, RCO, and ACP must demonstrate to the Medicaid Agency's approval the existence of an adequate Service Delivery Network that meets the requirements of this rule as demonstrated in part by executed provider contracts and/or Medicaid approved exceptions and as further demonstrated to the satisfaction of the Medicaid Agency which shall, except as otherwise provided herein, meet ninety percent (90%) of the Provider-Specific Network Criteria of section (e)(viii) above. The

Agency, in its sole discretion, may grant the RCO/ACP an exception of any Provider-Specific Network Criteria.

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

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

(B) The exception the RCO/ACP is requesting;

(C) Steps taken by the RCO/ACP to comply with requirement before requesting the exception;

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

(E) Description of the RCO/ACP's plan to adequately provide covered services if exception is granted.

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

(iii) If the Agency grants an exception, the RCO/ACP must submit quarterly reports to the Agency detailing enrollee access to the provider type subject to the exception.

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

(v) 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.

(d) Each entity must also submit documentation necessary to demonstrate that the RCO/ACP has the capacity to serve the expected enrollment in its service area and 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, NICU, 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 entity 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 probationary regional care organization, final regional care organization or alternate care provider 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 22-6-150 *et seq*; 42 C.F.R. § 438.68; 42 C.F.R. §§ 438.206 - 438.210.

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