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CHAPTER FORTY-FIVE

MATERNITY CARE PROGRAM

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Chapter 45 Maternity Care Program

Rule No. 560-X-45-.01 Authority and Purpose

(1) Pregnancy related care for Medicaid eligible women provided through the Maternity Care Program (MCP) is provided pursuant to the Alabama State Plan as approved by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) and the approved 1915(b) Waiver. The purpose of the program is to provide a comprehensive, coordinated system of obstetrical care to pregnant recipients.

(2) Coverage for the MCP includes the provisions of the Balanced Budget Act of 1997 and the subparts of the BBA Medicaid Managed Care regulation at 42 CFR Part 438.

(3) Program specifics are delineated in the Invitation to Bid (ITB) that is utilized for selection of Primary Contractors for the program.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.02 Eligibility

(1) Pregnant women participating in the program are determined Medicaid eligible by Medicaid and/or other approved certifying agencies through the normal eligibility process. Persons eligible for the MCP are women deemed pregnant through medical examination and/or laboratory tests.

(2) Recipients eligible for both Medicare and Medicaid shall not be enrolled.

(3) Providers shall access eligibility information through the Medicaid Automated Voice Response System or the appropriate electronic software for specific information on the county of residence and the pregnancy restriction to a Primary Contractor.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.03 Primary Contractor Standards

Primary Contractors must comply with the provisions of the executed contract, its amendments and referenced materials, the approved 1915(b) Waiver, and all other state and federal regulations governing the Medicaid program. The following outlines the standards for the Primary Contractor.

(1) Demonstrate the capability to serve all of the pregnant Medicaid eligible population in the designated geographical area.

(2) Procure a network of providers within a maximum of 50 miles travel for all areas of their district.

(3) Designate a full time Director for the district(s) who has the authority to make day to day decisions, implement program policy, and oversee the provision of care to qualified recipients according to Federal and State regulations.

(4) Establish business hours for the provision of maternity services. The Director or an appropriately qualified designee must be available and accessible during business hours for any administrative and/or medical problems which may arise.

(5) Require subcontractors providing direct care to be on call or make provisions for medical problems 24-hours per day, seven days per week.

(6) Require that all persons including employees, agents, subcontractors acting for or on behalf of the Primary Contractor, be properly licensed under applicable state laws and/or regulations.

(7) Comply with certification and licensing laws and regulations applicable to the Primary Contractor's practice, profession or business. The Primary Contractor agrees to perform services consistent with the customary standards of practice and ethics in the profession.

(8) Comply with State and Federal laws regarding excluded Individuals and Entities. The Primary Contractor agrees not to knowingly employ or subcontract with any health professional whose participation in the Medicaid and/or Medicare Program is currently suspended or has been terminated by Medicaid and/or Medicare.

(9) Require that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider only serves Medicaid recipients as required at 42 CFR 438.206(c)(1)(i).

(10) Establish mechanisms to ensure that the network providers comply with timely access requirements. The primary contractor shall monitor regularly to determine

compliance and shall take corrective action if there is a failure to comply. Access requirements are further defined at 42 CFR 438.206(c)(1)(iv)(v)(vi).

(11) Comply with all State and Federal regulations regarding family planning services and sterilizations, including no restriction on utilization of services.

(12) Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable

(13) Require accurate completion and submission of encounter data claims to support the validity of data used for statistical purposes and to set actuarial sound capitation rates.

(14) Cooperate with external review agents who have been selected by the State to review the Program.

(15) Report suspected fraud and abuse to the Alabama Medicaid Agency. In addition, these policies and procedures must comply with all mandatory State guidelines and federal guidelines as specified at 42 CFR 438.608(b)(1).

(16) Prohibit discrimination against recipients based on their health status or need for health services as specified at 42 CFR 438.6(d)(3)(4).

(17) Ensure that medical records and any other health and enrollment information that identifies any individual enrollee must be handled in such a manner as to meet confidentiality requirements as specified in 42 CFR 438.224. Each Primary Contractor must establish and implement procedures consistent with confidentiality requirements as specified in 42 CFR 438.224.

(18) The Primary Contractor is not required to provide, reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102(a)(b). If the Primary Contractor elects not to provide the service, then it must provide the related information to the State so that it can be provided to the recipient.

Author: Yulonda Morris, Program Coordinator and QA/QI Nurse, Maternity Care Program.
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
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Rule No. 560-X-45-.04 Primary Contractor Functions/Responsibilities

(1) Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality care. The care can be provided directly or through subcontracts.

(2) Implement and maintain the Medicaid approved quality assurance system by which access, process and outcomes are measured.

(3) Utilize proper tools and service planning for women assessed to be medically or psychosocially at risk.

(4) Provide recipient choice among Delivering Healthcare Professionals in their network.

(5) Meet all requirements of the Provider Network including maintaining written subcontracts with providers to be used on a routine basis including but not limited to, delivering physicians including obstetricians, family practitioners, general practitioners, anesthesiologists, hospitals, and care coordinators. For the first 30 days prior to contract start date and for the 1st month of each succeeding contract year, the Primary Contractor must offer opportunities for participation to all interested potential subcontractors.

(6) Notify the Agency, in writing, of changes in the subcontractor base including the subcontractor's name, specialty, address, telephone number, fax number and Medicaid provider number.

(7) Maintain a toll-free line and designated staff to enroll recipients and provide program information. If the Primary Contractor, subcontractors and recipients are within the local calling distance area a toll-free line is not necessary.

(8) Require subcontractors to comply with advance directives requirements.

(9) Develop, implement and maintain an extensive recipient education plan covering subjects, including but not limited to, appropriate use of the medical care system, purpose of care coordination, healthy lifestyles, planning for baby, and self-care. All materials shall be available in English and the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner including to those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments. The Primary Contractor must make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee.

(10) Develop, implement, and maintain a provider education plan, covering

subjects including but not limited to, program guidelines, billing issues, and updates from Medicaid. Provide support and assistance to subcontractors including but not limited to, program guidelines, billing issues, and updates from Medicaid. Education shall be provided semi-annually.

(11) Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of the Alabama Medicaid Agency MCP and the services it offers. The Primary Contractor is refrained from marketing activities as specified in Administrative Code 560-X-37-.01(17) and as further defined in 42 CFR 438.104(a) and 438.104(b)(1) et al. At a minimum, such education shall be provided semi-annually.

(12) Develop, implement and maintain a recipient program explaining how to access the MCP including service locations. Materials shall provide information about recipient rights and responsibilities, provisions for after-hours and emergency care, referral policies, notification of change of benefits, procedures for appealing adverse decisions, procedures for changing DHCP, exemption procedures and grievance procedures. All materials shall be available in English and in the prevalent non-English language in the particular service area. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments, and make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee.

(13) Develop, implement and maintain a grievance procedure that is easily accessible and that is explained to recipients upon entry into the system.

(14) Develop, implement and maintain a system for handling billing inquiries from recipients and subcontractors so that inquiries are handled in a timely manner.

(15) Develop, implement and maintain a computer based data system that collects, integrates, analyzes and reports. Minimum capabilities include recipient tracking, billing and reimbursement, data analysis and the generation of reports regarding recipient services and utilization.

(16) Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Primary Contractor by any subcontractor which may result in litigation related in any way to the subject matter of this Contract. In the event of the filing of a petition of bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Primary Contractor must ensure that all tasks related to any subcontractor are performed in accordance with the executed office.

(17) Ensure that subcontractor maintain for each recipient a complete record, including care coordination notes, at one location, of all services provided. Such information shall be accessible to the Primary Contractor and shall contain such information from all providers of service identified by recipient name, recipient number,

date of service, and services provided prior to making payment to that provider of service. It is acceptable to maintain one medical record and one administrative record (e.g. care coordination billing).

(18) Perform claims review prior to submission to Medicaid for Administrative Review.

(19) Advise recipients of services that may be covered by Medicaid that are not covered through the MCP.

(20) Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.

(21) Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee.

(22) Provide Application Assister services to Medicaid recipients.

(23) Develop a system to ensure all written materials are drafted in an easily understood language and format. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

(24) Provide Medicaid copies of all medical record documentation from subcontractors for medical record reviews and other quality related activities as applicable.

(25) Designate a person to enter data and manage Medicaid's Service Database entries for each district. This designee is responsible for the transmission of valid, timely, complete and comprehensive data, along with auditing the database periodically.

(26) Coordinate Service Database data entries for recipients transferring from one district to another district to ensure transmission of valid, timely, complete and comprehensive data entries.

Author: Yulonda Morris, Program Coordinator and QA/QI Nurse, Maternity Care Program.
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Wavier.
History: New ruled filed: August 22, 2005; effective November 16, 2005. **Amended:** Filed April 10, 2015; effective May 15, 2015.

Rule No. 560-X-45-.05 Payment to Primary Contractors

(1) Primary Contractors shall be reimbursed at a rate per global delivery as established through the open and competitive bid process.

(2) Reimbursement rates per global delivery shall be actuarially sound and must be approved by Centers for Medicare and Medicaid Services (CMS).

(3) Claims shall be submitted to Medicaid's Fiscal Agent for payment of the established rate through normal claim submission procedures.

(4) Payment for the delivery of the infant(s) and all pregnancy care is payment in full for all services provided that are covered by the MCP.

(5) Primary Contractors are not allowed to operate Physician Incentive Plans (PIPs) as explained in 42 CFR 422.208, 422.210 and 438.6(h) and 1903(m)(2)(A)(x) of the Social Security Act.

(6) Primary Contractors cannot hold the enrollee liable for covered services in the event of the entity's insolvency, non-payment by the State, or excess payments as specified at 1932 (b)(6) of the Social Security Act and 42 CFR 438.106, 438.6, 438.230 and 438.204.

Author: Yulonda Morris, Program Coordinator and QA/QI Nurse, Maternity Care Program.
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Wavier.
History: New ruled filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005. **Amended:** Filed April 10, 2015; effective May 15, 2015.

Rule No. 560-X-45-.06 Covered Services

(1) Primary Contractor Contractors shall have or arrange for a comprehensive system of maternity care that includes all services specified in the ITB used for selection of contractors. Detailed information regarding specific services covered by the MCP is provided in the ITB as well as the MCP Operational Manual

(2) Excluded services shall be covered fee for service by Medicaid. Any fee for service payment is made according to the benefit limits and coverage limitations applicable for the eligibility classification.

Author: Gloria S. Luster, Associate Director, Maternity Care Program.

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.07 Complaints and Grievances

(1) Each Primary Contractor shall implement an approved written grievance system that meets the requirements of 42 CFR 431.201 including, but not limited to:

(a) Designation of a responsible Grievance Committee.

(b) Two levels of review for the resolution of grievances. The time frame for these reviews shall be based on the nature of the grievance and the immediacy or urgency of the health care needs of the Medicaid recipient.

(c) The primary entry level for complaints shall be a designated responsible representative of each Primary Contractor.

(d) Resolution of grievances of an immediate or urgent nature (life threatening situations, perceived harm, etc.) shall not exceed a forty-eight hour review within the Primary Contractor's review process, which includes subcontractor's review. The Grievance Committee's decision shall be binding unless the Medicaid recipient files a written appeal.

(e) If the Medicaid recipient is not satisfied with the findings of the Grievance Committee, the Medicaid recipient may appeal to the Medicaid Agency for an administrative fair hearing.

(f) All grievances shall be maintained in a log as specified in the MCP Manual.

(2) Handling of Grievance and Appeals. The Primary Contractor must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State established timeframes and as specified in CFR 438.408, 438.410, 438.416, 438.420 and 438.424, including but not limited to:

(a) General Requirements. In handling grievances and appeals, the following requirements must be met:

1. Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing numbers that have adequate TTY/TTD and interpreter capability.

2. Acknowledge receipt of each grievance and appeal.

3. Ensure that the individuals who make decisions on grievances and appeals are individuals-

(i) Who were not involved in any previous level of review or decision making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(I) An appeal of a denial that is based on lack of medical necessity.

(II) A grievance regarding denial of expedited resolution of an appeal.

(III) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

2. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Primary Contractor must inform the enrollee of the limited time available for this in the case of expedited resolution.)

3. Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

4. Include, as parties to the appeal-

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

(3) Service Authorizations and Notice of Action

(a) An action is defined as the Primary Contractor

1. denying or limiting authorization of a requested service including the type or level of service;

2. reduction, suspension or termination of a previously authorized service;

3. the denial, in whole or part, of payment for a service;

4. the failure to provide services in a timely manner;

5. the failure to act within specified timeframes

(b) Adverse actions taken by the Primary Contractor must meet the requirements of 42 CFR 438.10, 438.12, 438.404 and 438.210-214.

(c) A service authorization is defined as an enrollee's request for the provision of a service.

(d) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must meet the requirements of 42 CFR 438.210.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.08 District Designation and Selection of Primary Contractors

(1) The number of Primary Contractors shall be restricted to one in each of the geographic districts within the State. Geographic districts are based on county designation and are generally comprised of multiple counties. Counties for specific districts shall be identified during the open and competitive bid process for a specified time period as per the ITB.

(2) Primary Contractors shall be selected through evaluation of the ability of the provider's ability to provide required components of the MCP submitted by prospective entities during the competitive bid process as more fully described in the MCP ITB specifications.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.09 Quality Improvement

(1) Each Primary Contractor shall provide an internal quality assurance (QA) system that meets all applicable state and federal guidelines and all quality requirements specified in the procurement document used in the bid process.

(2) Each Primary Contractor's Quality Assurance system shall include an ongoing quality assessment and performance improvement program as specified in 42 CFR 438.20 and a minimum of the following:

(a) Utilization control procedures for the on-going evaluation, on a sample basis, of the quality and accessibility of care provided to program participants

(b) Provide for review by appropriate health professionals of the process followed for providing health services

(c) Provide for systematic data collection of performance and patient results

(d) Provide for interpretation of this data

(e) Provide for making needed changes

(3) Primary Contractors shall have a structured and active Quality Assurance Committee, which shall:

(a) Be composed of, at a minimum, Program Director or designee, a board certified OB/GYN physician, a registered nurse with obstetrical experience, a licensed social worker, and hospital representation

(b) Meet at least quarterly, but more often as needed, to demonstrate that the Committee is following up on all findings and required actions

(c) Operates under the following parameters:

1. Information shall be treated as confidential in accordance with Medicaid rules and regulations and HIPAA - Health Insurance Portability and Accountability Act standards;

2. Committee shall identify actual and potential problems;

3. Committee shall develop appropriate recommendations for corrective action;

4. Committee shall perform follow-up on the recommendations to assure implementation of actions and continued monitoring, if necessary;

5. Committee shall collect data and analyze data;

6. Committee shall include utilization in quality assurance activities;

7. Committee shall include grievances in quality assurance activities;

8. Committee shall document all activities

(4) Each Primary Contractor shall have a written Quality Assurance (QA) Program description including:

(a) A scope of work which addresses both the quality and clinical care as well as non-clinical care.

(b) A written Quality Management plan which documents activities including: policies/procedures for performing chart reviews, utilization of provider and enrollee surveys, policies and procedures for analysis of data, procedures for analysis of administrative data and procedures for implementation of corrective action.

(c) A methodology for measurement which includes all demographic groups.

(d) Continuous performance of the activities to be tracked and the timeframes for reporting

(e) Feedback to health professionals regarding performance and patient results.

(f) Identification of individuals/organizations responsible for implementation of the QA plan.

(g) Identification of relevant and measurable standards of care (minimum requirements are contained in the MCP Operational Manual).

(h) Demonstration of measurable improvement of services being received through benchmarks (minimum requirements) are contained in the MCP Operational Manual).

(5) The Primary Contractor shall include in all subcontractor contracts and employment agreements a requirement securing cooperation with the Quality Assurance Program including access to records and responsible parties.

(6) Beneficiary survey results must be made available to the State upon request.

Author: Gloria S. Luster, Associate Director, Maternity Care Program

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.10 High Risk Protocols

(1) High risk care under the Maternity Care Program (MCP) shall be provided as outlined in the Invitation to Bid and the Maternity Care Operational Manual.

(2) Each recipient entering the MCP shall be assessed for high risk pregnancy status and referred to a Delivering Healthcare Professional qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites.

(3) Primary Contractors and their Delivering Healthcare Professionals are responsible for identification and referral of high risk recipients to the appropriate high risk referral site or appropriate high risk physician.

(4) A high-risk assessment tool approved by the Medicaid Agency shall be utilized in performing risk assessments.

(5) The reimbursement for high risk care provided by a Teaching Physician (as defined in Section 4.19-B of the State Plan) is excluded from the global and may be billed fee-for-service.

(6) The reimbursement for high risk care provided by a Medicaid Enrolled Board Certified Perinatalogist is excluded from the global and may be billed fee-for-service.

Author: Yulonda Morris, Program Coordinator and QA/QI Nurse, Maternity Care Program.
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005. **Amended:** Filed April 10, 2015; effective May 15, 2015.

Rule No. 560-X-45-.11 Care Coordination

(1) Each Primary Contractor shall ensure that each woman enrolled in the program receives care coordination. Care coordination is the mechanism for linking and coordinating segments of the service delivery system and assuring that the recipient

care needs are met and provided at the appropriate level of care. Care Coordination is a resource that ensures that the care received in the program is augmented with appropriate psychosocial support.

(2) Care coordination requirements are delineated in the bid specification and MCP Operational Manual and include, but are not limited to:

(a) Performing the initial encounter requirements
(b) Psychosocial risk assessment
(c) Assessing medical and social needs
(d) Developing service plans
(e) Providing information and education
(f) Patient tracking
(g) Encounters as specified throughout the course of the pregnancy.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.12 Health Care Professional Panel

(1) Primary Contractors shall have a delivery system that meets Medicaid standards as defined in the bid. The Primary Contractor shall ensure that there are sufficient health care professionals and hospitals to perform the required duties as specified in the ITB and contract with Medicaid.

(2) Participation opportunities for Delivering Health Care Professionals shall be offered as specified in the ITB.

(3) Primary Contractors shall continually monitor the health care panel to assure adequate access to care for program recipients. Services shall be available to the recipients within the 50-mile/50 minute standard as required by Medicaid.

(4) Primary Contractors shall utilize in-state providers if time/distance or medical necessity is not a factor.

(5) Primary Contractor shall notify Medicaid within one working day of any unexpected changes that would impair the network or create access to care issues.

(6) All subcontracts must meet the requirements of 42 CFR 438.6.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.13 Recipient Choice

(1) Women participating in the MCP shall be allowed to select the Delivering Health Care Professional of their choice from within the participating Delivering Health Care Professionals of the Primary Contractor. They may change professionals for cause at any time or without cause within 90 days of enrollment.

(2) Recipients who refuse to select a Delivering Health Care Professional shall be assigned one by the Primary Contractor who must follow assignment procedures specified in the MCP ITB.

(3) Lists of Delivering Health Care Professionals shall be maintained and utilized in the selection process.

(4) Recipients shall be provided all pertinent information about Delivering Health Care Professional as needed to make an informed selection. A toll free number must be available to recipients for use in selection of Delivering Health Care Professionals as well as for other questions/information.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. Amended: Filed August 22, 2005; effective November 16, 2005.