

Rule No. 560-X-62-.12 Service Delivery Network Requirements – NEW RULE

1. As referenced in this chapter, *primary medical provider* (PMP) is defined as one of the following:
 - a. Family practitioner
 - b. Federally Qualified Health Center
 - c. General Practitioner
 - d. Internist
 - e. Pediatrician
 - f. Obstetrician or gynecologist
 - g. Rural Health Clinic

2. As referenced in this chapter, *core specialist* is defined as each of the following:
 - a. Allergist
 - b. Anesthesiologist
 - c. Cardiologist
 - d. Cardiovascular Surgeon
 - e. Dermatologist
 - f. Gastroenterologist
 - g. General Surgeon
 - h. Neurologist
 - i. Oncologist
 - j. Ophthalmologist
 - k. Optometrist
 - l. Orthopedic surgeon
 - m. Psychiatrist
 - n. Pulmonologist
 - o. Radiologist
 - p. Urologist

3. As referenced in this chapter, *facility* is defined as each of the following:
 - a. Hospitals
 - b. Home Health Agency (*effective October 2018*)
 - c. Inpatient Psychiatric Hospitals
 - d. Laboratory Services
 - e. End Stage Renal Disease Treatment and Transplant Center
 - f. Outpatient Mental Health Center
 - g. Independent Radiology Center

4. As referenced in this chapter, *non-core specialist* is defined as any 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 or the RCO/ACP specifically if added value benefits are offered.

5. As referenced in this chapter, *service delivery network* is defined as one that meets and maintains, at a minimum, each of the following:

(a) Makes available and accessible all non-excluded services that are required under the State Plan to enrollees of the RCO/ACP.

(b) 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.

(c) Appropriately considers:

(i) The anticipated Medicaid enrollment

(ii) The expected utilization of services, taking into account the characteristics and health care needs of specific Medicaid populations represented in the particular RCO/ACP

(iii) The numbers and types of providers required to furnish the contracted Medicaid services

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

(vi) The geographic location of providers and Medicaid enrollees

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

(d) 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.

(e) 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	
Emergency Care	Immediate
Urgent Care	24 hours
Routine Sick Care	3 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
Office Wait Times	
Walk-Ins	2 hours or schedule an appointment within the standards of appointment availability
Scheduled Appointment	1 hour
Life-Threatening Emergency	Immediate

(f) Establishes appropriate policies and procedures to ensure compliance by providers with the above listed accessibility standards.

- (g) Monitors providers regularly to determine compliance.
- (h) Takes timely corrective action if there is a failure to comply.
- (i) Has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care.
- (j) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area. Although a provider type may not be listed above as a required PMP or Core Specialty type, the RCO/ACP must add additional specialties as needed to appropriately service its members and provide care delivery for all of the services and benefits covered by the RCO/ACP program or the RCO/ACP specifically if added value benefits are offered. These specialties are not required to be geographically located within the RCO's region.
- (k) 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 minimum network criteria are as follows:

Provider Type	Minimum Number	Distance
PMPs	1.5 per 1,000 enrollees, with a minimum of two	50 miles from each enrollee's residence
Core Specialists (for each of the types identified in subsection (2) of this rule)	0.2 per 1,000 enrollees	50 miles from each enrollee's residence
Non-Core Specialists	No requirement (<i>see subsection 4 of this rule</i>)	No requirement
Facilities (for each of the types identified in subsection (3) of this rule)	No requirement	50 miles from each enrollee's residence

- (l) Complies with all requirements of the furnishing of Medicaid services

6. 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.

7. Not later than April 1, 2015, each entity with probationary regional care organization certification must demonstrate to the Medicaid Agency's approval the ability to establish an adequate service delivery network and provide appropriate assurances and supporting documentation that the organization satisfies the requirements of subsection (5) of this rule.

8. Each entity must also submit documentation necessary to demonstrate that the RCO 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.

9. 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.

10. 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 CFR §§ 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 CFR §§ 438.206 - 438.210.

History: New Rule: Filed May 20, 2014.