

Rule No. 560-X-62-.09 Provider Standards Committee – NEW RULE

(1) Each regional care organization shall create a provider standards committee which shall review and develop the performance standards and quality measures required of a provider by the regional care organization.

(2) The performance standards reviewed and developed by a provider standards committee shall include, but not be limited to, provider performance benchmarks relating to the efficiency and management of care provided to Medicaid beneficiaries. Performance standards shall not include office hours, terms of reimbursement or the application of such standards in a contract between a regional care organization and a provider. The quality measures reviewed and developed by a provider standards committee shall include, but not be limited to, numeric quantification of results or outcomes of high-quality care experienced by Medicaid beneficiaries.

(3) The regional care organization shall promptly publish and distribute to its providers and the Medicaid Agency all performance standards and quality measures developed by the provider standards committee.

(4) The performance standards and quality measures shall be subject to the approval of the Medicaid Quality Assurance Committee established in Section 22-6-154 of the Alabama Code.

(a) If the regional care organization or a provider is dissatisfied with any performance standard or quality measure developed or approved by the provider standards committee, the regional care organization or provider who is dissatisfied may within 30 calendar days of publication of the performance standard or quality measure make a written request for review of the performance standard or quality measure to the Medicaid Quality Assurance Committee.

(b) Upon receipt of the request for review, the Medicaid Quality Assurance Committee shall request any information and documents to review the performance standard or quality measure at issue and the regional care organization or the provider shall have 10 calendar days to provide the Medicaid Quality Assurance Committee with the requested information and documents and any additional supporting information and documents that the regional care organization or provider wishes to present to the Medicaid Quality Assurance Committee. In addition, the chairperson of the provider standards committee shall have 10 calendar days to provide the Medicaid Quality Assurance Committee with requested information and documents concerning the basis, supporting studies and rationale for the performance standard or quality measure.

(c) The Medicaid Quality Assurance Committee shall either approve or disapprove the performance standard or quality measure at issue and shall promptly notify the regional care organization, the provider and the provider standards committee of its determination. Upon request by the Medicaid Quality Assurance Committee, the provider standards committee shall review any such approved performance standard or quality measure within six months after such approval and the provider standards committee shall provide the Medicaid Quality Assurance Committee a written report detailing the efficacy of said performance standard or quality measure. The Medicaid Quality Assurance Committee may withdraw its approval of the

performance standard or quality measure based upon the findings of the provider standards committee's report.

(d) No member of the Medicaid Quality Assurance Committee who also served on the provider standards committee which developed the performance standard or quality measure at issue shall vote or participate in the Medicaid Quality Assurance Committee's review of that performance standard or quality measure.

(e) No performance standard or quality measure reviewed or developed by the regional care organization's provider standards committee and/or by the Medicaid Quality Assurance Committee shall be subject to review pursuant to Section 22-6-153(g) or Rule No. 560-X-62-.11. The contractual application of these standards and measures shall be subject to review but not the performance standards or quality measures themselves.

(5) At least 60 percent of the members of the provider standards committee shall be physicians licensed in the State of Alabama who provide care to Medicaid beneficiaries served by the regional care organization. The medical practices of the physician members shall be consistent with and reflective of the medical services provided Medicaid beneficiaries in the Medicaid region.

(6) The provider standards committee shall also include at least three providers who are not physicians and who provide care or services to Medicaid beneficiaries served by the regional care organization.

(7) The regional care organization medical director shall serve as chairperson of the provider standards committee.

(8) No more than 50 percent of the members of the provider standards committee shall reside in one county of the Medicaid region.

(9) The members of the provider standards committee shall serve two-year terms.

(10) The provider standards committee shall meet at least semi-annually and at other times upon the written request of the chairperson or a majority of the members. Written notice indicating the date, time and place of each meeting shall be sent to each member of the provider standards committee not less than 7 calendar days prior to said meeting by the chairperson or any member of the committee; provided, however, that any member of the committee may waive his or her right to such notice and such waiver may be oral, by telephone, or by any such means of communication.

(11) The members of the provider standards committee may participate in a meeting of the committee by means of telephone conference, videoconference, or similar communications equipment by means of which all persons participating in the meeting may hear each other at the same time. Participation by such means shall constitute presence in person at a meeting for all purposes, including the establishment of a quorum.

(12) The Medicaid Agency may adopt and implement performance standards, quality measures and quality matrices in addition to or in conflict with the performance standards and quality measures adopted by a provider standards committee. In the event of any conflict between a performance standard, quality measure or quality matrix adopted by a provider standards committee and a performance standard, quality measure or quality matrix adopted by the Medicaid Agency, the performance standard, quality measure or quality matrix adopted by the Medicaid Agency shall supersede the performance standard, quality measure or quality matrix adopted by the provider standards committee.

(13) The Medicaid Agency shall decide any disagreement concerning whether a specific issue, dispute or matter is to be considered by a provider standards committee under this rule or a contract dispute committee under Rule No. 560-X-62-.11.

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Statutory Authority: Code of Alabama, 1975 Section 22-6-150 *et seq.*

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