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CHAPTER THIRTY-SEVEN

MANAGED CARE

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Rule No. 560-X-37-.01 General

(1) The Medicaid Agency may, at its discretion, and in consultation with local communities, organize and develop area specific systems as part of an overall managed care system.

(a) Flexibility. Since community needs and resources differ from area to area, the Medicaid Agency will maintain the flexibility to design plans which are consistent with local needs and resources.

(b) Waiver Programs. Plans may be either voluntary or mandatory pursuant to waiver(s) granted by the Centers for Medicare and Medicaid Services (CMS). Some plans may start as voluntary and subsequently become mandatory. All required federal waivers and/or approvals must be obtained by the Medicaid Agency before any system or contract can become effective.

(c) State Plan Programs. Amendments to the state plan must be approved by CMS before any system or contract can become effective.

(d) Models. The Medicaid Agency may utilize one or more managed care systems established in 42 C.F.R. Part 438 or approved by CMS, including but not limited to, health maintenance organizations (HMO), managed care organizations (MCO), prepaid ambulatory health plans (PAHPs), prepaid Inpatient health plans (PIHP), primary care case management systems (PCCM), and/or primary care case management entities (PCCM entity).

(e) Purpose. The purposes of managed care are to:

(i) Ensure needed access to health care;

(ii) Provide health education;

(iii) Promote continuity of care;

(iv) Strengthen the patient/physician relationship; and

(v) Achieve cost efficiencies.

(2) Any established managed care system shall comply with the following:

(a) the Alabama Medicaid State Plan and any award letters, waivers or other directives or permissions approved by CMS for operation of the managed care system;

(b) the Federal Medicaid Act, Title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP), established by Title XXI of the Social Security Act, and the Affordable Care Act, and their implementing regulations published in the Code of Federal Regulations (CFR), except as waived by CMS, including, but not limited to, 42 C.F.R. Parts 430, 432, 434, 438, 440, and 447, and as may be subsequently amended;

(c) any state law implementing or directing the implementation of the managed care system;

(d) Alabama Medicaid Administrative Code;

(e) the Alabama Medicaid Provider Manual and/or operational protocols, any Agency written policy, written procedure, written interpretation or other written guidance, including operational memos, manuals, interpretations, and Agency written communications; and

(f) all other applicable state and federal laws and regulations.

(3) Any managed care system or respective network provider shall comply with all applicable federal and state laws, rules, and regulations, including, but not limited to:

(a) Age Discrimination Act of 1975, as amended, 42 U.S.C. § 6101, *et seq.*;

(b) Age Discrimination in Employment Act of 1967, 29 U.S.C. §§ 621 – 634;

(c) Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12101, *et seq.*;

(d) Byrd Anti-Lobbying Amendment, 31 U.S.C. § 1352, 45 C.F.R. § 2543.87;

(e) Clean Air Act, 42 U.S.C. § 7401, *et seq.*;

(f) Debarment and Suspension 45 CFR § 74 Appendix A (8) and Executive Order (E.O.) 12549 and 12689;

(g) Equal Employment Opportunity, E.O. 11246, as amended by E.O. 11375, amending E.O. 11246 and as supplemented by 41 C.F.R., Part 60;

(h) Equal Pay Act of 1963, 29 USC § 206(d);

(i) Federal Water Pollution Control Act, as amended, 33 U.S.C. § 1251, *et seq.*;

(j) Immigration Reform and Control Act of 1986, 8 U.S.C. § 1324b;

(k) Rights to inventions made under a contract or agreement, 45 C.F.R. § 2543.85;

(l) Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794;

(m) Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d, *et seq.*;

(n) Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e;

(o) Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. § 1681; and

(p) Section 1557 of the Patient Protection and Affordable Care Act.

(4) The Medicaid Agency's contract with the managed care system must, at a minimum:

(a) include the applicable standard contract provisions of 42 C.F.R. § 438.3;

(b) include all applicable provisions required by 42 C.F.R. Part 438;

(c) include any provisions required by state or federal laws or regulations;

(d) be approved by CMS in accordance with to 42 C.F.R. § 438.3(a).

(5) Each managed care system must comply with the information requirements contained in 42 C.F.R. § 438.10. Unless otherwise specified in the manage care system contract or elsewhere by the Medicaid Agency, Prevalent Languages shall mean the fifteen (15) most spoken languages in the state as determined by the most recent United States Census.

(6) The Medicaid Agency must have policies and procedures in place to ensure that its obligations under 42 C.F.R. § 438 Subpart B are met. Further, Medicaid Agency employees must comply with the state ethics laws including, but not limited to, Code of Alabama (1975), Sections 36-25-5, -7, -8, -11, -12, and -13.

(7) Every managed care system must establish policies and procedures, which shall be subject to the Medicaid Agency's sole approval, to ensure that its obligations under its contract with the Medicaid Agency and 42 C.F.R. Subparts D and E are met. In addition, the Medicaid Agency must establish policies and procedures to monitor the managed care system's performance of its obligations.

(8) Every managed care system must establish, subject to the Medicaid Agency's sole approval, a grievance system. Such grievance system must, at a minimum:

(a) comply with the applicable provisions of 42 C.F.R. § 438 Subpart F; and

(b) comply with any other applicable state or federal laws and regulations.

Author: Jerri Jackson, Director, Managed Care Division
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Social Security Act, Title XI and Title XIX, Section 1903(m); 42 C.F.R. Section 434.26, 42 C.F.R. Section 434.6; Part 438.
History: Effective date July 12, 1996. Amended December 14, 2001. **Amended**: Filed March 20, 2003; effective June 16, 2003. **Amended**: Filed August 13, 2013; effective September 17, 2013. **Amended:** Filed February 9, 2018; effective March 26, 2018.

Rule No. 560-X-37-.02 Primary Care Case Management (PCCM)

(1) Under this model of managed care, each patient/recipient is assigned to a primary medical provider (PMP) who is a physician who is responsible for managing the recipient's

health care needs. This management function neither reduces nor expands the scope of covered services.

(a) PCCM services means case management related services that include location, coordination, and monitoring of primary health care services; and are provided under a contract between Medicaid and the PMP or the PMP group.

(b) PCCM services may be offered by the state as a mandatory option under the Medicaid state plan; with the exception of beneficiaries who are dually eligible for Medicare and Medicaid, American Indians/Alaska Natives, or children with special health care needs.

(2) Primary Medical Providers (PMP)

PMPs are generally family practitioners, general practitioners, internists or pediatricians. If a patient's condition warrants, PMPs of another specialty may be assigned if he/she is willing to meet all contractual requirements. Patients may be assigned to the individual physician. Patients may be assigned to a group of physicians, if approved by the Medical Director.

(3) The Patient 1st PMP agrees to do the following:

(a) Accept enrollees as a primary medical provider in the Patient 1st Program for the purpose of providing care to enrollees and managing their health care needs.

(b) Provide Primary Care and patient coordination services to each enrollee in accordance with the provisions of the Patient 1st agreement and the policies set forth in the Alabama Medicaid Administrative Code, Medicaid provider manuals and Medicaid bulletins and as defined by Patient 1st Policy.

(c) Provide or arrange for Primary Care coverage for services, consultation, management or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Patient 1st Policy.

(d) Provide EPSDT services as defined by general Medicaid and Patient 1st Policy.

(e) Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees as defined by Patient 1st Policy.

(f) Maintain a unified patient medical record for each enrollee following the medical record documentation guidelines as defined by Patient 1st Policy.

(g) Promptly arrange referrals for medically necessary health care services that are not provided directly, document referral for specialty care in the medical record and provide the authorization number to the referred provider.

(h) Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of primary medical provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request. Enrollees cannot be charged for copies.

(i) Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Patient 1st Policy.

(j) Refer for a second opinion as defined by Patient 1st Policy.

(k) Review and use all enrollee utilization and cost reports provided by the Patient 1st Program for the purpose of practice level utilization management and advise the Agency of

errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Patient 1st Policy.

(l) Participate with Agency utilization management, quality assessment, complaint and grievance, and administrative programs.

(m) Provide the Agency, its duly authorized representatives and appropriate federal Agency representatives unlimited access (including onsite inspections and review) to all records relating to the provision of services under this agreement as required by Medicaid policy and 42 C.F.R. 431.107.

(n) Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines.

(o) Notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not made within 30 days of change, then future participation may be limited.

(p) Give written notice of termination of this agreement, within 15 days after receipt of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis, by the PMP.

(q) Refrain from discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.

(r) Refrain from discriminating against individuals eligible to enroll on the basis of race, color, or national origin and will refrain from using any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

(s) Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

(t) Make oral interpretation services available free of charge to each potential enrollee and enrollee. This requirement applies to all non-English languages.

(u) Receive prior approval from the Agency of any Patient 1st specific materials prior to distribution. Materials shall not make any assertion or statement (whether written or oral) that the recipient must enroll with the PMP in order to obtain benefits or in order not to lose benefits. Materials shall not make any assertion or statement that the PMP is endorsed by CMS, the Federal or State government or similar entity.

(v) Refrain from door-to-door, telephonic or other 'cold-call' marketing or engaging in marketing activities that could mislead, confuse, or defraud Medicaid Recipients, or misrepresent the PMP, its marketing representatives, or the Agency.

(w) Refrain from knowingly engaging in a relationship with the following:

- an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
- an individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

- As a director, officer, partner of the PMP,
- A person with beneficial ownership of more than five percent (5%) or more of the PMP 's equity; or,
- A person with an employment, consulting or other arrangement with the PMP for the provision of items and services that are significant and material to the PMP's contractual obligation with the Agency.

(x) Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before the original 3-year period ends.)

(y) Provide the Agency within 30 day's notice of PMP disenrollment or change in practice site. This will allow for an orderly reassignment of enrollees. Failure to provide 30 day's notice may preclude future participation and/or result in recoupment of case management fees.

(4) Recipients can choose or will be assigned to a PMP prior to the PMP assignment in the PCCM program. Recipients have the ability to change PMPs on a monthly basis. Changes must be requested prior to the 15th of the month for the change to be effective the first of the following month.

(5) In order to participate in the PCCM program, a provider must sign an agreement with Medicaid that will detail the requirements of the PCCM program. PMPs will be paid a monthly medical case management fee for primary care case management services in an amount determined by the Agency. The fee will be based on the number of recipients enrolled for the provider on the first day of each month.

(6) The Case Management fee will be automatically paid to the PMP on the 1st check write of each month. The PMP will be reimbursed a capitation fee per member per month for each recipient assigned and will receive an additional fee for those recipients identified with chronic conditions if the PMP is contracted with a Health Home. The monthly enrollment summary report will indicate the individual amount of case management fee being paid for that month. Case management fees are not subject to third party liability requirements as specified in 42 CFR 434.6(a)(9). All direct services are paid fee-for-service through medical claims processing procedures based on the regular Medicaid fee schedule. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) will not receive the case management fee each month.

(7) PMPs are limited to 1200 recipients unless additional numbers are approved by Medicaid. The Agency may increase the number of recipients based on historical caseload; documentation of a predominately Medicaid practice and/or employment of midlevel practitioners.

(8) The failure of a PMP to comply with the terms of this agreement or other provisions of the Medicaid Program governed under Social Security Act Sections 1932, 1903(m) and 1905(t) may result in the following sanctions by the Agency:

(a) Limiting member enrollment with the PMP.

(b) Withholding all or part of the PMP's monthly Patient 1st management/coordination fee.

(c) Referral to the Agency's Program Integrity or Quality Assurance Unit for investigation of potential fraud or quality of care issues.

(d) Referral to Alabama Medical Board or other appropriate licensing board.

(e) Termination of the PMP from the Patient 1st program.

One or more of the above sanctions may be initiated simultaneously at the discretion of the Agency based on the severity of the agreement violation. The Agency makes the determination to initiate sanctions against the PMP. The PMP will be notified of the initiation of a sanction by certified mail. Sanctions may be initiated immediately if the Agency determines that the health or welfare of an enrollee(s) is endangered or within a specified period of time as indicated in the notice. If the PMP disagrees with the sanction determination, he has the right to request an evidentiary hearing as defined by Patient 1st Policy.

Failure of the Agency to impose sanctions for an agreement violation does not prohibit the Agency from exercising its rights to do so for subsequent agreement violations.

Author: Latonda Cunningham, Associate Director, Patient 1st Program
Statutory Authority: Sections 1915(b)(1)(2)(3), and (4): Sections 1902 (a)(i), (10) and (23) of the Social Security Act, 42 CFR 431.55; 438.2; 440.168.
History: **New Rule:** Filed June 21, 2004; effective September 15, 2004; **Amended:** Filed January 11, 2018; effective February 26, 2018.

Rule No. 560-X-37-.03 Prepaid Inpatient Health Plan (PIHP)

(1) A prepaid inpatient health plan (PIHP) is one that provides services to enrolled recipients on a capitated basis but does not qualify as a HMO.

(2) Capitated PIHPs do not need to meet the requirements of §1903(m)(2)(A) of the Social Security Act if services are less than fully comprehensive. Comprehensive services are defined as:

(a) Inpatient hospital services and one or more services or groups of services as follows:

(i) Outpatient hospital services;
(ii) Laboratory and X-ray services;
(iii) Nursing facility (NF) services
(iv) Physician services;
(v) Home health services;
(vi) Rural health clinic services;
(vii) FQHC services;
(viii) Early and periodic screening, diagnostic, and treatment (EPSDT) services; and
(ix) Family planning services.

(b) No inpatient services, but three or more services or groups of services listed in Section (2)(a).

(3) If inpatient services are capitated, but none of the additional services listed in Section (2)(a) above are capitated, the entity may be considered a PIHP.

(4) The Partnership Hospital Program (PHP) is a non-comprehensive Prepaid Inpatient Health Plan (PIHP) operating under the Medicaid state plan. The following further describes the Partnership Hospital Program:

(a) It is an inpatient care program.

(b) It is mandatory for Medicaid recipients, with the exception of recipients with Part A Medicare coverage, SOBRA adults who are enrolled in and receive inpatient care through the Maternity Care program in counties covered by the PHP, and children certified through the Children's Health Insurance Program (CHIP).

(c) It is composed of prepaid inpatient health plans organized by districts in the State of Alabama.

(d) PIHPs operate under the authority granted in the Partnership Hospital Program, a state plan service as approved by CMS.

(e) Medicaid reimburses the prepaid inpatient health plans participating in the Partnership Hospital Program on a per member per month capitation basis.

(f) Prepaid inpatient health plans provide medically necessary inpatient care for covered Medicaid recipients including:

(i) Bed and board
(ii) Nursing services and other related services
(iii) Use of hospital facilities
(iv) Medical social services
(v) Drugs, biologicals, supplies, appliances and equipment
(vi) Certain other diagnostic and therapeutic services, and
(vii) Medical or surgical services provided by certain interns or residents-in-training.
(viii) Excluded are inpatient family planning services and inpatient emergency services.

(g) Prepaid inpatient health plans will assist the participant in gaining access to the health care system and will monitor on an inpatient basis the participant's condition, health care needs, and service delivery.

(h) Prepaid inpatient health plans are responsible for locating, coordinating, and monitoring all inpatient care in acute care hospitals within the state.

(i) Systems required of prepaid health plans, at a minimum, include:

(i) Quality assurance and utilization review systems
(ii) Grievance systems
(iii) Systems to furnish required services, including utilization review
(iv) Systems to prove financial capability
(v) Systems to pay providers of care

(5) The PIHP and Medicaid shall operate a quality assurance (QA) program sufficient to meet those quality review requirements of 42 CFR Part 438, Subpart D, applicable to PIHPs and their providers. The QA Program and any revisions must be approved in writing by Medicaid.

(a) The PIHP shall appoint a QA Committee to implement and supervise the QA Program. This committee shall consist of not less than three healthcare professionals, who may be members of the PIHP board, employees of providers or such other persons in the healthcare field as the PIHP believes will be required to oversee the creation and control of a successful QA Program for the PIHP.

(b) The QA Program shall be a written program specifying:

(i) Utilization control procedures for the on-going evaluation, on a sample basis, of the need for, and the quality and timeliness of care provided to Medicaid eligibles by the PIHP.

(ii) Review procedures by appropriate health professionals of the process, following the provision of health services.

(iii) Procedures for systematic data collection of performance and patient results.

(iv) Procedures for interpretation of these data to the provider.

(v) Procedures for making needed changes.

(c) The QA Committee shall employ a professional staff to obtain and analyze data from Medicaid information systems, the provider hospitals, and such other sources as the staff deems necessary to carry out the QA Program. All costs of the QA Program shall be paid by the PIHP.

(d) PIHP member hospitals shall conduct continuing internal reviews of their own QA programs. The QA Committee staff shall be given all such assistance and direction by such provider QA programs and shall obtain such reasonable information from such providers as may be necessary to implement the PIHP QA Programs.

(e) The staff shall implement such focused medical reviews of the providers as may be required by Medicaid, required under the QA Program, or believed necessary the staff.

(f) Medicaid staff shall coordinate with the PIHP's QA Committee and staff on QA matters. Medicaid shall make such audits and surveys as it deems reasonably required, but shall do at least one annual medical audit on each PIHP and all of its providers. The PIHP shall provide all information, medical records, or assistance as may be reasonably required for Medicaid to conduct such audits.

(g) Medicaid QA personnel will make periodic on-site visits to review and monitor the QA Program and assess improvements in quality. The PIHP shall make certain all necessary information and records are available at such sites.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Part 434 and 438; State Plan Attachment 4.19-A(f)
History: Rule amended July 12, 1996. Emergency rule effective October 1, 1996. Amended January 14, 1997; January 12, 1998; June 16, 2003.
Amended: Filed April 7, 2004; effective July 16, 2004.

Rule No 560-X-37-.04 Health Maintenance Organizations (HMO)

(1) Health Maintenance Organizations (HMO~~s~~) means any entity or corporation that undertakes to provide or arrange for basic health care services through an organized system which combines the delivery and financing of health care to enrollees. The organization shall provide physician services directly through physician employees or under contractual

arrangements with either individual physicians or a group of physicians. The organization shall provide basic health care services directly or under contractual arrangements. When reasonable and appropriate, the organization may provide physician services and basic health care services through other arrangements. The organization may provide, or arrange for, health care services on a prepayment or other financial basis.

(2) Covered services shall be provided to each eligible enrollee and will be reimbursed on a monthly capitation basis.

(3) The HMO is required to obtain a Certificate of Authority to operate as a HMO in the State of Alabama, issued by the Department of Insurance prior to providing services. HMOs must obtain a Certificate of Need (CON) or a letter of non-reviewability from the State Health Planning Agency. When applicable, the HMO may also be required to participate in an Invitation to Bid process as directed by the Medicaid Agency.

(4) The HMO shall make adequate provisions against the risk of insolvency as contained in the Code of Alabama Section 27-21A-12 and as specified in the contract between the HMO and Medicaid. The HMO must ensure that individuals eligible for benefits are never held liable for debts of the plan.

(5) HMOs desiring to participate as a managed care provider should contact the Medical Services Division at Medicaid. HMOs must submit written documentation for approval which includes, but is not limited to, the following:

(a) Description of services to be provided
(b) Marketing Plan and any marketing materials to be used by the plan
(c) Quality Assurance Plan
(d) Enrollment Plan
(e) Education Plan
(f) Copy of Certificate of Authority
(g) Copy of Certificate of Need or letter of non-reviewability
(h) Examples of subcontracts to be utilized by the plan
(i) Proposed enrollment sites
(j) Enrollment area
(k) Grievance procedures

All of the above information must be sent before the review can be completed.

(6) The HMO must ensure contracted health services required by the enrollees are available and accessible through a system that arranges for primary and preventive care provided by and coordinated through a Medicaid enrolled Primary Care Physician (PCP).

(7) Enrollment

(a) In geographical areas that are served by a freedom-of-choice waiver, enrollment in an approved HMO is mandatory for those recipients included in the waiver.

Recipients will have the opportunity to voluntarily enroll in an HMO during the open enrollment period, if applicable.

(b) In the event that a recipient who resides in an area that has a freedom-of-choice waiver does not select an HMO, Medicaid will mandatorily assign that recipient to an HMO. In an area where only one HMO is operational under an approved 1115 waiver, the recipient will be required to select a PCP within the HMO's network or be assigned. This will be done according to a formula which meets the needs of the State and the recipients and which is communicated to all health plans in advance. This formula may consist of rotation among the HMOs. Medicaid will notify the HMO of the recipients mandatorily enrolled in their plan via computer compatible media. Recipients that have been mandatorily assigned will also be notified by Medicaid. The effective date of enrollment generally will be the first day of the month following a full calendar month after assignment to an HMO. It is the HMO's responsibility to send to Medicaid monthly, on computer compatible media, all current enrollees, new enrollees and disenrollments.

(8) Disenrollment

(a) When an enrollee becomes ineligible for Medicaid benefits, is deceased, moves out of the service area, or is changed to a non-covered aid category; the effective date of disenrollment will be the first day of the month following documentation of the change on the Managed Care File.

(b) Any enrollee may elect to disenroll from an HMO, with or without cause, and enroll in another where multiple HMOs participate in the Medicaid program in that area. Recipients are required to submit a written disenrollment request to the HMO with a reason documented in the patient file and on the monthly enrollment information. Disenrollment is effective the first day of the month following a full calendar month after receipt of the disenrollment on the monthly enrollment information.

(c) Unless otherwise specified in an approved waiver, an HMO may disenroll an enrollee whose behavior is disruptive, unruly, abusive, or uncooperative, and not caused by a medical condition, to the extent that his membership in the HMO seriously impairs the HMO's ability to furnish services to that enrollee or other members of the HMO. The HMO is required to provide at least one verbal and one written warning to the enrollee regarding the implication of his actions. No member can be involuntarily disenrolled without the prior written approval of Medicaid.

(d) Unacceptable reasons for an HMO to disenroll an enrollee include pre-existing medical conditions, changes in health status, and periodic missed appointments.

(e) Enrollees may be disenrolled for knowingly committing fraud or permitting abuse of their Medicaid card. Disenrollment of this nature must be promptly reported to Medicaid and must be prior authorized by Medicaid.

(f) The HMO's responsibility for all disenrollments includes supplying disenrollment forms to enrollees desiring to disenroll; ensuring that completed disenrollment forms are maintained in an identifiable enrollee record; ensuring that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so; and ensuring that disenrollees receive written notification of the effective date of and reason for disenrollment. HMOs must submit voluntary disenrollments on the first electronic submission sent to Medicaid after the request is received by the HMO.

(9) Marketing

(a) The Medicaid Agency may elect to enroll recipients through contracted enrollment vendors. If the State chooses to use vendors, HMOs will not be allowed to enroll or recruit patients through marketing representatives.

(b) The HMO shall submit the written marketing plan, procedures, and materials to Medicaid for approval prior to implementation. Enrollment of recipients may not begin until the marketing plan has been approved by Medicaid.

(c) The HMO shall not engage in marketing practices that mislead, confuse, or defraud enrollees, providers, or Medicaid. Mailings, gifts of a material nature, telecommunication and door-to-door marketing are subject to prior approval by the Alabama Medicaid Agency.

(d) Accurate, clear, readable, and concise information shall be made available to eligible recipients and providers in the area serviced by the HMO. Such information shall include, but not be limited to: covered services, location, telephone number, hours of service, enrollment, disenrollment, grievance procedures, and what to do in case of an emergency.

(e) No more than fifty percent (50%) of a marketing representative's total annual compensation, including salary, benefits, bonuses and commission, shall come from commissions.

(10) Grievance Procedures

(a) The HMO shall have a written internal grievance procedure that is approved by Medicaid.

(b) The HMO must have written procedures for prompt and effective resolution of written enrollee grievances.

(c) The HMO must include a description of the grievance system including the right to appeal decisions.

(d) The HMO must maintain records of all oral complaints and written grievances in a log (hard copy or automated).

(e) The HMO must make provisions to accept and resolve grievances filed by individuals other than enrollees.

(11) Quality Assurance

(a) The HMO's Quality Assurance Plan (QAP) must objectively and systematically monitor and evaluate the quality and age appropriateness of care and services through quality of care studies and related activities by following written guidelines predicated on the Quality Assurance Reform Initiative (QARI) which must include:

(i) Goals and objectives;
(ii) Scope;
(iii) Specific activities;
(iv) Continuous activities;
(v) Provider review; and
(vi) Focus on health outcomes.

(b) The Governing Body of the HMO must be responsible for, or designate an accountable entity within the organization to be responsible for, oversight of the QAP.

(c) Each HMO must designate a committee responsible for the performance of QA functions accountable to the Governing Body.

(d) The QAP must objectively and systematically monitor and evaluate the quality and appropriateness of care and service through quality of care studies and related activities.

(e) Each HMO must designate a senior executive to be responsible for QAP implementation and the Medical Director must have subsequent involvement in QAP activities.

(f) The QA Committee must have, as members HMO providers representative of the composition of all providers of service.

(g) The QAP must include provisions for credentialing and recredentialing of health care professionals who are licensed by the State.

(h) HMOs shall allow Medicaid's authorized representative, on an annual basis, to conduct an external independent quality review to analyze the quality of services furnished by the HMO to ensure adequate delivery of care. The results of the review shall be made available to Medicaid, and upon request, to the Secretary of HHS, the Inspector General, and the Comptroller General.

(12) Records

(a) An appropriate record system shall be maintained for all services (including ancillary services) provided to all enrollees. Such records shall be stored in a safe manner to prevent damage and unauthorized use. Records will be reasonably accessible for review.

(b) Entries on medical records shall be authenticated and written legibly in ink or typewritten.

(c) Records must contain all pertinent information relating to the medical management of each enrollee reflecting all aspects of patient care in a detailed, organized and comprehensive manner consistent with medical practice standards.

(d) The HMO shall make available at no cost to Medicaid, the Department of Health and Human Services, and to their designees, any records of the provider and/or subcontractors which relate to the HMO's ability to bear risks for the services performed, amounts paid for benefits, quality review, and any other requested documentation.

(13) Reporting

(a) The HMO shall furnish any information from its records to HHS, the Comptroller General, and/or their agents which may be required to administer the contract. At a minimum, the HMO shall furnish to Medicaid, and to authorized representatives, in a manner and form specified by Medicaid:

(i) Business transactions to include:

a. Any sale, exchange or lease of any property between the HMO and a party in interest;

b. Any lending of money or other extension of credit between the HMO and a party in interest; and

c. Any furnishing for consideration of goods, services (including management services) or facilities between the Plan and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions listed above between an HMO and a party in interest includes the name of the party in interest for each transaction, a description of

each transaction and the quality of units involved, the accrued dollar value of each transaction during the fiscal year and justification of the reasonableness of each transaction.

(ii) Proposed changes to the marketing plan, procedures or materials;
(iii) Monthly enrollment data to include name, Medicaid number, payee number, and PCP assignment number;
(iv) Utilization data concerning enrollees in the Plan as required by contract;
(v) Summaries of all complaints and all grievances received by the HMO under this contract and actions taken to resolve complaints and grievances quarterly and annually.
(vi) Summaries of amounts recovered from third parties for services rendered to enrollees under the HMO;
(vii) A list of payments made by the HMO during the past month for services purchased through referral and subcontracted providers;
(viii) Encounter data claims submitted directly to Medicaid's fiscal agent for all services paid for or provided by the HMO to enrollees in previous months; and
(x) All other reports as specified and defined in the Managed Care Provider Manual/Operational Protocol and contract.

(b) The HMO will keep and make available to Medicaid, HHS, the Comptroller General, and their agents or authorized representatives, any of the HMO's records which are necessary to fully disclose and substantiate the nature, quality, cost, and extent of items and services provided to enrollees. The HMO shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of five years from the date of the last payment made by Medicaid to the HMO under this contract. However, when audit, litigation, or other action involving records is initiated prior to the end of the five (5) years period, records shall be maintained for a period of five (5) years following the completion of such action and the resolution of all actions which arise from it. Plans shall fully complete and submit to Medicaid quarterly financial statements. Quarterly reports are due for periods ending March 31, June 30, September 30, and December 31 and must be submitted within 45 days of the end of the reporting period or the HMO shall pay a penalty of $100.00 for each day the financial report is delinquent. In addition, the National Association of Insurance Commissioner's Annual Statement Blank, must be fully completed by Contractor annually and submitted to Medicaid. The HMO's annual report must be submitted no later than March 1 or Contractor shall pay to Medicaid a penalty of $100.00 for each day the annual report is delinquent. However, the Commissioner of Medicaid shall have the option to waive the penalty with shown proof by the HMO of good cause for the delay. In addition, the HMO must submit an audited financial statement to Medicaid covering the fiscal year within 90 days of the end of its fiscal year. Contractor shall also promptly submit any and all other financial information requested by Medicaid, HHS, or the Comptroller General.

(14) Payment

(a) Capitation payments to the HMO for all eligible enrollees shall be made monthly.

(b) The HMO shall accept the capitation fees as payment in full for Medicaid benefits provided and shall require its providers to accept payments in full for Medicaid benefits provided.

(c) Neither managed care enrollees nor Medicaid shall be held liable for debts of the HMO in the event of the organization's insolvency.

(d) In-plan covered services must be provided by the HMO chosen by the recipient. These services can be provided directly, through subcontract providers, or by non-contract out-of-plan providers when appropriately referred.

(e) If an enrollee utilizes a non-contract provider for in-plan service, other than emergency services, family planning services, and services provided by a Federally Qualified Health Center (FQHC), the HMO, to the extent allowed by law, may not be held liable for the cost of such utilization unless the HMO referred the enrollee to the non-contract provider or authorized the out-of-plan utilization. Payment by the referring HMO for properly documented claims shall not exceed the maximum fee-for-service rates applicable for the provider for similar services rendered under the Alabama Medicaid Program, unless otherwise agreed upon by the HMO and the non-contract provider. No reimbursement shall be available directly from Medicaid for in-plan services provided by non-contract providers. If there is an FQHC in the geographical area being served by a HMO that contracts with one or more HMO's, an enrollee may elect to join the HMO contracting with the FQHC in order to receive the services offered by the FQHC. If no FQHC in the area agrees to contract with any of the HMOs, the HMOs are obligated to reimburse the FQHC if an enrollee elects to receive services from this entity.

(15) Compliance Review Committee

(a) Alabama Medicaid shall establish a Compliance Review Committee (CRC). The purpose of the CRC is to facilitate resolution of issues related to compliance with the requirements of the contract between the HMO and Medicaid.

(b) Administrative sanctions are reserved for managed care program abuses. Sanctions may be imposed by the Agency for failure to comply with Agency program requirements.

(c) In all cases of HMO abuse, restitution of improper payments or monetary sanctions may be pursued in addition to any administrative sanctions imposed. Administrative sanctions include, but are not limited too, probation. During probation, an HMO may have the number of enrollees it serves limited to a fixed number by the Agency for a set period of time. The HMO will be notified if probation has been authorized for a specific period of time and at the termination of the probation, the HMO will be subject to a follow-up review of its Medicaid Managed Care practice.

(d) The decision as to the sanction(s) to be imposed shall be at the discretion of the Medicaid Commissioner based on the recommendation(s) of the staff of the Managed Care Division, the CRC or other appropriate program review personnel.

(e) The following factors shall be considered in determining the sanctions to be imposed:

(i) Seriousness of the offense(s)

(ii) Extent of violations and history of prior violations

(iii) Prior imposition of sanctions

(iv) Actions taken or recommended by Peer Review Organizations or licensing boards

(v) Effect on health care delivery in the area

When an HMO is reviewed for administrative sanctions, the Agency shall notify the HMO of its final decision and the HMO's entitlement to a hearing in accordance with the Alabama Administrative Procedure Act.

(16) Childrens Health Insurance Program (CHIP)

Children eligible as CHIP children, aged up to 19, who reside in counties in which HMO coverage is available may be included in the program.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Attachment 4.18-A; Social Security Act, Title XI and Title XIX, Section 1903(m); 42 C.F.R. Section 434 et seq.; Civil Rights Act of 1964, Titles VI and VII, as amended. Code of Alabama 1975, Section 22-21-20, et seq., Section 27-21A-1, et seq., and 41-22-1, et seq. The Federal Age Discrimination Act. Rehabilitation Act of 1973. The Americans with Disabilities act of 1990.
History: Effective date is July 12, 1996. Amended January 12, 1998. **Amended**: Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-37-.05 Medicare Health Maintenance Organizations (MHMOs) and Competitive Medical Plans (CMPs)

(1) A Medicare Health Maintenance Organizations (MHMO) and Competitive Medical Plans (CMP) are organizations which may contract with the Health Care Financing Administration (HCFA) to enroll Medicare beneficiaries and other individuals and groups to deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to its Medicare enrollees. An HMO or CMP must be organized under the laws of the State and must meet HCFA's qualifying criteria, as specified in 42 C.F.R. §417.410-.418, in order to enter into a contract with HCFA to enroll Medicare beneficiaries.

A Competitive Medical Plan, as defined in 42 C.F.R. §417.407(c), is a legal entity, which provides to its enrollees at least the following services: services performed by physicians; laboratory, x-ray, emergency, and preventive services; out-of-area coverage; and inpatient hospital services. The entity receives compensation by Medicaid for the health care services it provides to enrollees on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any enrollee. The entity provides physician services primarily through physicians who are employees or partners of the entity or physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physician services. The entity assumes full financial risk on a prospective basis for provision of health care services, but may obtain insurance or make other arrangements as specified in 42 C.F.R. §417.120 and .407. The entity must provide adequately against the risk of insolvency by meeting the fiscal and administrative requirements of 42 C.F.R. §417.120(a)(1)(i) through (a)(1)(iv) and 417.122(a).

(2) The Alabama Medicaid Agency may reimburse a fixed per member per month (PMPM) capitated payment established by Medicaid to HMOs and CMPs which have an

approved Medicare risk contract with the Health Care Financing Administration for beneficiaries who enroll in a Medicare HMO or CMP for which Medicaid is responsible for payment of medical cost sharing. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. This PMPM payment will cover, in full, any premiums or cost sharing required from the Medicare Plan. The PMPM payment will be established based on historical costs and negotiations.

(3) Medicare HMOs and CMPs may enroll with the Medicaid Agency to receive capitated payments for beneficiary premiums and cost sharing by executing a Memorandum Of Understanding with the Medicaid Agency. To enroll the following must be submitted to Medicaid:

(a) A copy of HCFA approval for a Medicare risk contract to enroll Medicare beneficiaries;

(b) A copy of the HMO or the CMP's member services handbook; and

(c) A copy of Certificate of Authority (COA) from the Alabama Insurance Department and appropriate approvals for a material modification to a COA.

(4) All services covered by Medicare shall be covered by the HMO or CMP at no cost to the beneficiary. In addition, the HMO or CMP may offer additional services to the beneficiary (e.g. hearing exams, annual physical exam, eye exams, etc.). The HMO or CMP must notify the Alabama Medicaid Agency prior to adding additional services (identified by procedure code) available to the beneficiary through the Plan. Services covered directly by Medicaid which are not covered by Medicare are not included in the Plan.

(5) The beneficiary will be given freedom of choice in selecting a primary care provider through the Medicare HMO or CMP.

(6) The Medicare HMO or CMP is required to submit a monthly electronic enrollment listing to Medicaid in a format specified by Medicaid.

Authority: State Plan 3.2(a)(10)(E)(i). Social Security Act §1905(p)(1). 42 C.F.R. Section 434.20, Section 434.26, Section 434.23, Section 434.29, Section 434.38, Section 434.6. Effective date is July 12, 1996.

Rule No. 560-X-37-.06 Reserved

Rule No. 560-X-37-.07 Regional Care Organizations (RCO)

The Alabama Medicaid Agency is responsible for the development and oversight of a Regional Care Organization (RCO) program as part of an overall managed care system within the state. This program will promote accountability for a patient population, coordinate items and services under Medicaid, and encourage investment in the infrastructure of care processes for higher quality and more efficient services provided to Medicaid beneficiaries.
Geographic Boundaries

(a) Effective October 1, 2013 the following designations of geographic boundaries have been established for RCO locations:

Region A includes Colbert, Cullman, Franklin, Jackson, Lauderdale, Lawrence, Limestone, Madison, Marshall, and Morgan counties.

Region B includes Blount, Calhoun, Cherokee, Chilton, Cleburne, Clay, Coosa, Dekalb, Etowah, Jefferson, Randolph, Shelby, St. Clair, Talladega, Tallapoosa and Walker counties.

Region C includes Bibb, Choctaw, Fayette, Greene, Hale, Lamar, Marengo, Marion, Perry, Pickens, Sumter, Tuscaloosa, and Winston counties.

Region D includes Autauga, Barbour, Bullock, Butler, Chambers, Crenshaw, Coffee, Covington, Dale, Dallas, Elmore, Geneva, Henry, Houston, Lee, Lowndes, Macon, Montgomery, Pike, Russell and Wilcox counties.

Region E includes Baldwin, Clarke, Conecuh, Escambia, Mobile, Monroe, and Washington counties.

(b) Each region will be capable of supporting a minimum of two RCOs or alternate care providers.

Author: Nancy Headley, Director, Managed Care Division
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Social Security Act, Title XI and Title XIX, Section 1903(m)(2) (B); Act 2013-261.
History: New Rule filed: August 13, 2013. Effective: September 17, 2013.