TABLE OF CONTENTS

CHAPTER SIXTY-FOUR

INTEGRATED CARE NETWORKS

Rule	Title	Page
560-X-64-.01	Certificate in Order to Collaborate With other Entities, Individuals, or Integrated Care Net Works	1
560-X-64-.02	Active Supervision of Collaborations	4
560-X-64-.03	Governing Board of Directors	5
560-X-64-.04	Citizens' Advisory Committee	7
560-X-64-.05	ICN Quality Assurance Committee	8
560-X-64-.06	Solvency and Financial Requirements for Integrated Care Networks	11
560-X-64-.07	Service Delivery Network Requirements for Integrated Care Networks	15
560-X-64-.08	Active Supervision of Organizations with Probationary Certification	22
560-X-64-.09	Qualification Criteria for Participation in the Mandated Competitive Procurement for Integrated Care Networks	23
560-X-64-.10	Financial Reporting and Audit Requirements	24
560-X-64-.11	Hazardous Financial Condition and Insolvency	28
560-X-64-.12	Probationary Certification of Organizations Seeking to Become Integrated Care Networks	32
560-X-64-.13	Conflict of Interest Policy for Directors and Officers of Integrated Care Networks	37

560-X-64-.14	Right to Terminate Certificates of Probationary and Fully Certified Integrated Care Networks	39
560-X-64-.15	Grievances and Fair Hearings of Integrated Care Networks	40
560-X-64-.16	Reserved – ICN Covered Population	42
560-X-64-.17	Reserved – ICN Covered Services	42
560-X-64-.18	Sanctions	42
560-X-64-.19	Reserved – Readiness Assessment Requirements	45

Rule No. 560-X-64-.01 Certificate in Order to Collaborate with other Entities, Individuals, or Integrated Care Networks

(1) Every person or entity who is operating or may operate as a Collaborator shall possess a certificate (Certificate to Collaborate) issued by the Medicaid Agency qualifying such person or entity to collaborate as set forth in Section 22-6-233 of the Alabama Code. A Collaborator is defined in Section 22-6-220(2) of the Alabama Code as: "A private health carrier, third party purchaser, provider, health care center, health care facility, state and local governmental entity, or other public payers, corporations, individuals, and consumers who are expecting to collectively cooperate, negotiate, or contract with another collaborator or integrated care network in the health care system."

(2) Every person or entity seeking a Certificate to Collaborate shall submit an on-line application with the Medicaid Agency and must include the following information in the application:

(a) The applicant's name, business, occupation or medical specialty, principal address and the name, mailing address, e-mail address, and telephone number of each person authorized to receive notices and communications relating to the application;

(b) As applicable, the applicant's National Provider Identifier (NPI) number(s), Medicaid ID number(s), Taxpayer Identification Number(s) (TIN), Social Security Number (SSN) and any state professional or facility license number(s);

(c) The name and address of each individual who the applicant authorizes to collaborate on its behalf with other entities, persons, Integrated Care Networks (ICNs), or Regional Care Organizations (RCOs);

(d) Background information relating to the applicant and each individual authorized to collaborate on its behalf, including:

(i) whether the applicant or any individual authorized to collaborate on its behalf is currently excluded or suspended from the Medicare, Medicaid, or the Title XX services program;

(ii) whether the applicant or any individual authorized to collaborate on its behalf has ever pled guilty to or been convicted of a criminal offense related to the applicant's or the individual's involvement in any program under Medicare, Medicaid, or the Title XX services program;

(iii) whether the applicant or any individual authorized to collaborate on its behalf has ever pled guilty, been convicted, or found liable in a criminal or civil proceeding of engaging in any form of health care fraud or abuse;

(iv) whether the applicant or any individual authorized to collaborate on its behalf has ever pled guilty, been convicted, or found liable in a criminal or civil proceeding of engaging in any form of anti-competitive conduct or other anti-trust violation;

(v) whether the professional license or certification of the applicant or any individual authorized to collaborate on its behalf is currently suspended or revoked; and

(vi) whether the applicant or any individual authorized to collaborate on its behalf has ever pled guilty or been convicted of a violation of the state or federal securities or insurance laws.

(e) Information whether the applicant intends to help establish or develop an ICN, to enroll as a provider with an ICN, or to engage in other activity.

(f) Description of what entities and persons with whom the applicant intends on collaborating or negotiating;

(g) Description of the expected effects of the negotiated contract, including whether the negotiated contract is expected to:

(i) result in improved quality of health care services and/or Long-Term Care Services, as defined in Section 22-6-220(5) of the Alabama Code, to Medicaid beneficiaries;

(ii) result in cost containment in providing health care services and/or Long-Term Care Services;

(iii) result in enhancements in technology; and

(iv) maintain competition in the health care services market and/or the Long-Term Care Services market.

(h) Certification by the applicant that all information entered on the application is true, to the best of the applicant's knowledge, and (1) that the applicant will bargain in good faith as contemplated in Section 22-6-233 of the Alabama Code, (2) that such bargaining is necessary to identify appropriate service delivery systems and reimbursement methods in order to align incentives in support of integrated and coordinated long-term healthcare delivery, and (3) that such bargaining is necessary to provide quality health care to Alabama citizens who are Medicaid eligible at the lowest possible cost.

(3) The Medicaid Agency may inspect or request additional documentation and information from an applicant as the Medicaid Agency deems appropriate before issuance of a Certificate to Collaborate or at any other time to verify that the Medicaid laws are implemented in accordance with the legislative intent.

(4) (a) The Medicaid Agency shall review the application and any additional documentation and information and, if the Medicaid Agency determines that the applicant has made a sufficient showing that the collaboration is in order to facilitate the development and establishment of the ICN or long-term health care payment reforms, the Medicaid Agency shall issue a Certificate to Collaborate.

(b) Certificates to Collaborate issued by the Medicaid Agency pursuant to this rule and Section 22-6-233 of the Alabama Code shall be issued to allow collective negotiations, bargaining, and

cooperation among Collaborators and ICNs in accordance with Sections 22-6-220, *et seq*. of the Alabama Code.

(c) A Certificate to Collaborate shall be effective immediately upon issuance by the Medicaid Agency and shall expire on October 1, 2018. The Medicaid Agency may implement rules for renewals of Certificates to Collaborate.

(d) The holder of a Certificate to Collaborate (Certificate Holder) shall promptly notify the Medicaid Agency online of any substantial or material corrections or updates to the information provided in the Certificate Holder's application.

(5) All applications submitted pursuant to this rule, all Certificates to Collaborate, and the names and addresses of all persons and entities to whom the Medicaid Agency issues Certificates to Collaborate shall be public records and shall be subject to disclosure. The names and addresses of all Certificate Holders and all individuals authorized to collaborate on behalf of Certificate Holders shall be posted on the Medicaid Agency's website for review.

(6) The Medicaid Agency shall actively monitor and supervise collective negotiations, bargaining, contracting, and cooperation among Collaborators and ICNs in accordance with Sections 22-6-220, *et seq*. of the Alabama Code. As part of its monitoring and supervision, the Medicaid Agency shall, as it deems appropriate, request periodic reports and additional information regarding the status, progress being made and problems encountered in the collaborative process, and the status of efforts to create integrated networks intended to provide for the delivery of a coordinated system of long-term healthcare. Failure to file a periodic report or to provide information or documents requested by the Medicaid Agency is grounds for revocation of a Certificate to Collaborate.

(7) Any person or entity may notify the Medicaid Agency of conduct of a Certificate Holder that is alleged to violate any of the certifications by the Certificate Holder pursuant to Section 22-6-233(c) of the Alabama Code and subsection 2(h) of this rule. The notice must be signed, in writing and include a statement of facts supporting the allegation of a violation. Upon receipt of such notice or upon receipt of such information obtained by Medicaid on its own, the Medicaid Agency shall review the notice and conduct any inquiry it finds appropriate and may refer the allegation of a violation to the State of Alabama Attorney General. The Medicaid Agency may revoke a Certificate to Collaborate upon finding that the Certificate Holder has violated any of the certifications by the Certificate Holder pursuant to Section 22-6-233(c) of the Alabama Code and subsection 2(h) of this rule or it may in its discretion impose additional terms and conditions determined necessary to effectuate the objectives of the Certificate to Collaborate.

(8) Should Collaborators or an ICN be unable to reach an agreement, they may request that the Medicaid Agency intervene and facilitate negotiations.

(9) The Medicaid Commissioner or the Medicaid Commissioner's designee(s) may enter into discussions with, meet with, or convene Collaborators and ICNs to facilitate the development and establishments of the ICNs and long-term health care payment reforms and discuss questions, concerns, or complaints related thereto.

(10) Given the important governmental and public interest to ensure that state action immunity is not conferred upon persons or entities who fail to sufficiently show that their collaboration is in furtherance of the goals of Section 22-6-220 *et seq.* of the Alabama Code, all decisions to grant, deny, or revoke, a Certificate to Collaborate shall serve as the final decision of the Medicaid Agency and shall be appealable immediately to circuit court. Notwithstanding this rule, a holder of a Certificate to Collaborate that is revoked for failure to provide a timely periodic report or other requested information or documents, may apply for reinstatement of the Certificate to Collaborate no more than two times (which number may be expanded by the Medicaid Agency for special circumstances as determined in the Medicaid Agency's sole discretion) upon submission of the delinquent periodic report or information, an explanation for failure to provide a timely periodic report or other requested information, and any other information deemed necessary by the Medicaid Agency.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq.*
History: Emergency Rule filed and effective March 22, 2016. **Amended**: Filed June 10, 2016; effective: July 25, 2016.

Rule No. 560-X-64-.02 Active Supervision of Collaborations

(1) The Medicaid Agency shall actively monitor and supervise the collective negotiations, bargaining, contracting, and cooperation among Collaborators that have been issued Certificates to Collaborate by the Medicaid Agency and Integrated Care Networks (ICNs) in accordance with Sections 22–6–220, *et seq.* of the Alabama Code. Each Collaborator issued a Certificate to Collaborate shall submit an on-line periodic report to the Medicaid Agency no later than June 1 and December 1 of each year in which the Collaborator holds a Certificate to Collaborate.

(2) Each periodic report must contain the information requested by the Medicaid Agency in order to allow the Medicaid Agency to engage in appropriate state supervision in accordance with Section 22–6–233 of the Alabama Code, including the following information:

(a) A description of the Collaborator's activities during the reporting period conducted pursuant to the Certificate to Collaborate, including a description of what entities and persons with whom the Collaborator engaged in collective negotiations, bargaining, or cooperation during the reporting period;

(b) A description of any progress the Collaborator has made during the reporting period in helping establish or develop an ICN or enrolling as a provider with an ICN;

(c) A description of any concerns or problems encountered in the collaborative process during the reporting period;

(d) A description of the nature and scope of expected future activities pursuant to the Certificate to Collaborate; and

(3) Each periodic report submitted by a Collaborator who intends to help establish or develop an ICN must include additional information concerning whether the ICN is expected to:

(a) result in improved quality of health care services and/or Long-Term Care Services, as defined in Section 22-6-220(5) of the Alabama Code, to Medicaid beneficiaries;

(b) result in cost-containment in providing health care services and/or Long-Term Care Services;

(c) result in enhancements in technology;

(d) maintain competition in the health care services market and/or the Long-Term Care Services market; and

(e) identify appropriate service delivery systems and reimbursement methods in order to align incentives in support of integrated and coordinated health care delivery and/or Long-Term Care Services delivery.

(4) The Collaborator shall certify in each periodic report that the bargaining during the reporting period was in good faith and necessary to meet the legislative intent expressed in Section 22-6-233 of the Alabama Code.

(5) The Medicaid Agency may inspect or request additional information, inspect or request documentation, and may convene meetings, make inquiries, and have such discussions with entities and persons it deems appropriate.

(6) Failure to file a periodic report required by this rule and failure to provide information or documents requested by the Medicaid Agency are each grounds for revocation of a Certificate to Collaborate pursuant to Rule 560-X-64-.01(10). A holder of a Certificate to Collaborate that is revoked for failure to provide a timely periodic report or other requested information or documents may apply for reinstatement of the Certificate to Collaborate no more than two times (which number may be expanded by the Medicaid Agency for special circumstances as determined in the Medicaid Agency's sole discretion) upon submission of the delinquent periodic report or information, an explanation for failure to provide a timely periodic report, and any other information deemed necessary by the Medicaid Agency.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq.*
History: Emergency Rule filed and effective March 22, 2016. **Amended**: Filed June 10, 2016; effective: July 25, 2016.

Rule No. 560-X-64-.03 Governing Board of Directors

(1) An integrated care network shall have a governing board of directors composed of the following twenty members:

(a) Twelve members shall be persons representing risk-bearing participants in the integrated care network. A participant bears risk by contributing cash, capital, or other assets to the integrated care network.

(i) Six of the twelve risk-bearing participants shall be long-term health care or medical providers, or representatives thereof, who serve or will serve Medicaid beneficiaries enrolled in the integrated care network.

(ii) The long-term health care or medical providers must collectively contribute cash, capital, or other assets approved by the Agency to satisfy at least fifty percent of the capital and surplus requirements of Alabama Medicaid Administrative Code Chapter 560-X-64.

(b) Eight members shall be persons who do not represent a risk-bearing participant in the integrated care network and are not employed by a risk bearing participant. At least four of these members must be long-term health care or medical providers who serve or will serve Medicaid beneficiaries enrolled in the integrated care network.

(i) Two members shall be appointed by the Medical Association of the State of Alabama, or its successor organization;

(ii) One member shall be appointed by the Alabama Hospice and Palliative Care Organization, or its successor organization;

(iii) One member shall be a representative of an organization that is part of the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations;

(iv) One member shall be a representative of the Alabama chapter of AARP or the Alabama Disabilities Advocacy Program, or their successor organizations;

(v) One member shall be a representative of the Disability Rights and Resources or the Arc of Alabama, or their successor organizations;

(vi) The chair of the citizen's advisory committee established pursuant to Alabama Medicaid Administrative Code Rule 560-X-64-.04; and,

(vii) One members shall be a community representatives.

(2) A majority of the members of the board may not represent a single provider. Any provider shall meet licensing requirements set by law, shall have a valid Medicaid provider number, and shall not be otherwise disqualified from participating in Medicare or Medicaid.

(3) Medicaid shall have the power to approve the members of the governing board and the board's structure, powers, bylaws, or other rules of procedure. No organization shall be granted integrated care network certification without approval.

(4) Any vacancy on the governing board of directors in connection with non-risk bearing members appointed as described in Section 22-6-221(d)(1) shall be filled by the appropriate authority. A vacancy in a board of directors' seat held by a representative of a risk-bearing participant as defined in Section 22-6-221(d)(1)(a) shall be filled by a majority vote of the remaining directors of the integrated care network. Notwithstanding other provisions of this rule, the Medicaid Commissioner shall fill a board seat left vacant for more than three months.

(5) The governing board may, by resolution adopt by a majority of the directors, appoint an executive committee, which shall consist of two or more directors, who may have such authority and take such action as authorized by the governing board and consistent with state law; provided, however, any at-risk provider type shall be represented on the executive committee. For purposes of this subsection, a legal entity shall be considered the same provider type of the majority owner(s), principal(s) or member(s) of that entity. The governing board shall set policy and direction for the integrated care network and the executive committee shall execute the policies established by the governing board. The governing board may also appoint such other committees as are consistent with Alabama law. All actions of the executive committee and all other committees shall be reported to the governing board. At least one member of an executive committee and any other committee shall be one of the members appointed to the board by the Medical Association of the State of Alabama.

(6) The governing board shall meet at least quarterly. If provided for in the ICN's bylaws, a member may participate and/or vote in a meeting of the governing board of directors by means of telephone conference, videoconference, or similar communications equipment only if:

(a) All persons participating in the meeting may hear each other at the same time.

(b) The meeting of the governing board of directors is conducted at a physical location whereby members have the option to attend the meeting in-person. Participation by such means shall constitute presence in person at a meeting for all purposes, including the establishment of a quorum.

(7) All appointing authorities for the governing board and the executive committee shall coordinate their appointments so that diversity of gender, race, and geographical areas is reflective of the makeup of the population served.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq.*
History: New Rule: Filed December 12, 2016; effective January 26, 2017

Rule No. 560-X-64-.04 Citizens' Advisory Committee

(1) A citizens' advisory committee (CAC) shall advise an integrated care network (ICN) on ways it may be more efficient in providing quality care to Medicaid beneficiaries. In addition, a CAC shall carry out other functions and duties assigned to it by the ICN and approved by the Medicaid Agency. Each ICN shall have a CAC, which membership shall be inclusive and reflect the racial, gender, geographic, urban/rural, and economic diversity of the population served. The committee shall meet all of the following criteria:

(a) Be selected in a method established by the ICN and approved by the Medicaid Agency.

(b) At least 20 percent of its members shall be Medicaid beneficiaries or sponsors of Medicaid beneficiaries or, if the ICN has been certified as an integrated care network, at least 20 percent of its members shall be Medicaid beneficiaries enrolled in the integrated care network, or the Medicaid beneficiary's sponsor. It shall be the ICN's sole responsibility to obtain all necessary approvals, consents or waivers from Medicaid beneficiaries and to comply with all applicable laws regarding privacy and confidentiality related to such information before providing it to the Medicaid Agency.

(c) Include members who are representatives of organizations that are part of the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations, the Alabama chapter of AARP, the Alabama Disabilities Advocacy Program, the Disability Rights and Resources, the Arc of Alabama, and also include members who are non-at-risk providers that provider services to Medicaid beneficiaries through the integrated care network.

(d) Elect a chair.

(e) Meet at least every three months.

(2) A member may participate and/or vote in a meeting of the CAC by means of telephone conference, videoconference, or similar communications equipment. Participation by such means shall constitute presence in person at a meeting for all purposes, including the establishment of a quorum. Such participation is permitted only if:

(a) All persons participating in the meeting may hear each other at the same time;

(b) The equipment necessary to participate in the meeting is readily available to all members of the committee; and

(c) The meeting of the CAC is conducted at a physical location whereby members have the option to attend the meeting in-person.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq.*
History: New Rule: Filed December 12, 2016; effective January 26, 2017

Rule No. 560-X-64-.05 ICN Quality Assurance Committee

(1) Pursuant to Section 22-6-227 of the Alabama Code, the Medicaid Agency ("Agency") shall have an integrated care network (ICN) quality assurance committee ("Committee") appointed by the Medicaid Commissioner.

(a) The members of the Committee shall serve two-year terms.

(b) At least 60 percent of the members shall be long-term health and medical care providers who provide care to Medicaid beneficiaries served by an ICN.

(c) In making appointments to the Committee, the Medicaid Commissioner shall seek input from the appropriate stakeholders and professional associations.

(d) The Medicaid Commissioner shall also select an alternate to each appointed committee member who shall be permitted by the Committee Chair to participate and/or vote in the event of an appointed member's absence pursuant to subsection (4)(d) of this rule. The alternate shall meet the same appointment criteria as the absent member for whom the alternate is selected.

(e) The Medicaid Commissioner may also appoint Ex Officio members to the Committee. Ex Officio members are not counted for quorum purposes or for the composition requirement of subsection (1)(b) above, and are exempt from the alternate member rule in subsection (1)(d) above.

(2) The Committee shall identify objective outcome and quality measures for nursing facility services, home-based and community-based support services, and any other such long-term health and medical care services the Agency requires to be provided by an ICN. These measures should include, but not be limited to:

(a) identifying individuals needing Long Term Service Supports (LTSS);

(b) delivering person centered planning;

(c) providing adequate access to services; and,

(d) progressing toward rebalancing in the delivery of services.

(3) Quality measures adopted by the Committee shall not conflict with existing state and national quality measures.

(4) The Committee shall meet at least bi-annually to review quality, performance and outcomes measures and make recommendations to the Agency for modifications to measures for the upcoming calendar year.

(a) A quorum of a simple majority (50 percent +1 member) of the Committee members (or their selected alternates) shall be required to take such action on behalf of the Committee.

(b) The Committee shall approve or disapprove outcome and quality measures based on a simple majority vote of those present and eligible to vote.

(c) If approved by the Committee Chair, a Committee member 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 not constitute presence in person at a meeting for all purposes, including the establishment of a quorum.

(d) In the event that a Committee member is unable to participate in a Committee meeting, the Committee Chair shall, upon receipt of advance written, facsimile or email request from the member explaining the reason for the member's absence, permit the alternate member selected by the Medicaid Commissioner pursuant to subsection (1)(d) of this rule to participate and/or vote in the member's place.

(5) The Committee shall recommend quality measures to the Agency to include in the ICN Quality Assessment and Performance Improvement program which will be included in contractual agreement(s).

(6) The Quality Assessment and Performance Improvement Plans developed by ICNs shall consult with the Committee prior to approval by the Agency.

(7) Outcome and quality measures, established in accordance with this Rule, shall be used to review the care rendered through an ICN.

(a) The Committee shall adopt outcome and quality measures annually and adjust the measures to reflect the following:

(i) Shifts and changes in utilization that reflect rebalancing and enhancements in the delivery of services.

(ii) Changes in membership (ICN enrolled population) of the organization.

(iii) A community health assessment conducted by a state agency.

(iv) Percentage of population served in a community setting.

(b) The Agency shall continuously evaluate the outcome and quality measures adopted by the Committee and make adjustments to the outcome and quality measures as necessary.

(c) The Medicaid Commissioner shall, where appropriate, incorporate outcome and quality measures established by the Committee into each ICN contract to hold the organizations accountable for their performance and consumer satisfaction evaluation measures.

(8) The Agency shall require each ICN to provide electronic encounter, assessment data, claims management, and all other relevant information on all applicable beneficiaries in a format approved by the Agency. Information shall include, but is not limited to:

(a) Diagnosis, Setting of Care, Committee approved quality measures, hospitalization, coordination of care and outcomes.

(b) Any other information, as specified by the contract between an ICN and the Agency, or data required by CMS, that is necessary for the Agency to evaluate the performance and outcomes achieved through the coordination of LTSS by an ICN.

(9) The Agency shall utilize available data systems for reporting outcome and quality measures adopted by the Committee and take actions to eliminate any redundant reporting or reporting of limited value.

(10) The Medicaid Agency shall publish the information collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published shall report, by ICN, all of the following:

(a) Quality measures;

(b) Costs and financial performance;

(c) Outcomes; and,

(d) And other information, as specified by the contract between an ICN and the Agency, that is necessary for the Agency to evaluate the value of health services delivered by an ICN.

(11) Except as otherwise provided in rules promulgated by the Agency, the Committee shall not participate in the data validation or performance evaluation of an ICN by the Agency.

(12) Each ICN shall create a provider standards committee which shall review and develop the performance standards and quality measures required of a provider by the ICN. The performance standards and quality measures shall be subject to the approval of the Committee.

(13) No member of the Committee, including Ex Officio members, who has a potential conflict of interest with a particular quality measure or performance standard shall vote or participate in the Committee's review of that performance standard or quality measure.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-227; 42 CFR Part 438.
History: Emergency Rule filed and effective October 20, 2016. Filed December, 12, 2016; effective: January 26, 2017.

Rule No. 560-X-64-.06 Solvency and Financial Requirements for Integrated Care Networks

(1) Each integrated care network (ICN), as a condition of final certification or continued final certification, and as a condition to the risk contract between the Medicaid Agency and the ICN, shall maintain minimum financial reserves and capital or surplus at the following levels:

(a) Restricted reserves in an amount equal to 20 percent of the ICN's average monthly total capitation payment (as defined in section 4 of this rule); and

(b) Capital or surplus, or any combination thereof, of four million dollars ($4,000,000), which shall not be satisfied by an irrevocable letter of credit provided pursuant to section 2 of this rule.

(2) The Medicaid Agency may, in its sole discretion, add to, reduce, or otherwise alter, amend, adjust, or modify the minimum financial reserves and capital or surplus described in section (1) of this rule to account for the level of financial and/or other risk the ICN bears with regard to the populations to be served or the services to be provided by the ICN, or any other factor the Agency considers relevant to the financial solvency of the ICN.

(3) Instead of maintaining the restricted reserves required by subsection 1(a) of this rule, an ICN may submit to the Medicaid Agency an irrevocable letter of credit in an amount equal to the aggregate restricted reserves that would otherwise be required of the ICN under subsection 1(a), to guarantee the performance of the provisions of the risk contract, satisfying the following requirements:

(a) The irrevocable letter of credit shall be issued by a federally or State of Alabama chartered banking institution with assets in excess of four billion dollars ($4,000,000,000) authorized to do business in the State of Alabama and approved by the Medicaid Agency.

(b) No assets of the ICN shall be pledged or otherwise encumbered in connection with the irrevocable letter of credit.

(c) The irrevocable letter of credit by its terms shall be effective through the date that is 30 days after the latest date that the ICN's risk contract could expire, in accordance with its terms, including any extension periods.

(d) The irrevocable letter of credit shall be approved by the Medicaid Agency as to form and content and shall be payable to the Medicaid Agency within five (5) calendar days of the Medicaid Agency's presentation of a notice to the issuing bank stating that the Medicaid Agency has determined in its sole discretion that the ICN is in breach or default under the risk contract. No proof of breach or default shall be required.

(e) In addition to the foregoing and such other terms and conditions as shall be required by the Medicaid Agency, the irrevocable letter of credit shall require that the bank notify the Medicaid Agency in writing within ten business days after the occurrence of any delinquency in payment of any fee by the ICN or giving of notice of default to the ICN by the bank. The irrevocable letter of credit shall also require that the bank give the Medicaid Agency 30 calendar days' advance written notice prior to termination or nonrenewal of the irrevocable letter of credit or any other material adverse action to be taken by the bank with respect to the irrevocable letter of credit.

(4) Each ICN other than ICNs satisfying their restricted reserve requirements with an irrevocable letter of credit shall, using a model depository agreement provided by the Medicaid Agency, establish a restricted reserve account with a third party financial institution that is authorized to do business in the State of Alabama and is satisfactory to the Medicaid Agency for the purpose of holding the ICN's restricted reserve funds required pursuant to subsection 1(a) of this rule.

(a) Restricted reserves shall be held for the exclusive purpose of making payments to providers in the event of a determination by the Medicaid Agency pursuant to Rule No. 560-X-64-.08 that the ICN is insolvent, is in a hazardous financial condition, or is otherwise in breach or default under the risk contract.

(b) Each ICN shall provide a copy of its executed model depository agreement to the Medicaid Agency as a condition of final certification or continued final certification, and as a condition to the risk contract between the Medicaid Agency and the ICN and such model depository agreement shall remain in effect throughout the term of the risk contract, including any renewals thereof, unless and until the ICN provides an irrevocable letter of credit in compliance with section 2 of this rule.

(c) The following are considered eligible deposits for the purposes of the restricted reserve requirements:

(i) Cash;

(ii) Certificates of deposit satisfying standards approved by the Medicaid Agency; and

(iii) Bonds, notes, warrants, debentures, and other evidences of indebtedness which are direct obligations of the United States of America for which the full faith and credit of the United States of America is pledged for the payment of principal and interest.

(5) For purposes of calculating an ICN's required restricted reserves pursuant to subsection 1(a) of this rule, “average monthly total capitation payment” means the mathematical average of the total capitation payment pursuant to the risk contract for each of the three months during the preceding calendar quarter. Within 30 calendar days after the end of each calendar quarter, each ICN’s required restricted reserves shall be adjusted based on the average monthly total capitation payment for such preceding quarter. Until an ICN has completed a full calendar quarter of its risk contract, the ICN’s projected average monthly total capitation payment shall be determined by the Medicaid Agency, based on a projection of the capitation payment to be paid to the ICN if the Medicaid Agency enters into a risk contract with the ICN. Such projected average monthly expenditures may be adjusted by the Medicaid Agency from time-to-time through the completion of the first full calendar quarter of the ICN’s risk contract, based upon changes in the projected or the actual capitation payment under the risk contract.

(6) For purposes of subsection 1(b) of this rule and Section 22-6-223 of the Alabama Code, an ICN's capital and surplus is the difference between the admitted assets of the ICN and the liabilities of the ICN, determined as follows:

(a) The classification and value of the ICN's assets and liabilities shall be determined in accordance with Generally Accepted Accounting Principles (GAAP) and Generally Accepted Auditing Standards (GAAS), as modified by the provisions of this section 5.

(b) For purposes of this rule, "admitted assets" means only assets owned exclusively by the ICN consisting of:

(i) Cash, including the true balance of deposits in solvent banks and trust companies;

(ii) Bonds, notes, warrants, debentures, and other evidences of indebtedness which are direct obligations of the United States of America for which the full faith and credit of the United States of America is pledged for the payment of principal and interest ("U.S. Treasury Securities");

(iii) Investment grade bonds or other evidences of indebtedness other than U.S. Treasury Securities, satisfying standards approved by the Medicaid Agency;

(iv) Marketable equity securities, satisfying standards approved by the Medicaid Agency;

(v) Due or deferred capitation payments pursuant to the risk contract between the ICN and the Medicaid Agency;

(vi) The acquisition cost of land and depreciated cost of improvements thereon owned by the ICN and used in connection with the performance of the risk contract, in excess of any liabilities secured by encumbrances on such assets, in an aggregate amount not greater than 50 percent of the required minimum capital and surplus of the ICN; and

(vii) Such other assets as may be approved by the Medicaid Agency.

(c) In addition to assets not described in subsection 5(b) of this rule, an ICN's admitted assets shall not include:

(i) Any single investment or asset, or any combination of investments in or secured by the securities, obligations, and/or property of one person, entity, or governmental unit, to the extent any such investment or combination of investments would exceed 20 percent of the ICN's admitted assets, provided that the foregoing restriction shall not apply to U.S. Treasury Securities or cash; or

(ii) Goodwill and other intangible assets.

(d) In any determination of the capital and surplus of an ICN, liabilities to be charged against the ICN's admitted assets shall include, in addition to other liabilities chargeable in accordance with GAAP and GAAS:

(i) The amount necessary to pay all of the ICN's unpaid losses and claims incurred on or prior to the date of the statement, together with the expenses of adjustment or settlement thereof;

(ii) Federal, state, and local taxes, expenses and other obligations due or accrued at the date of the statement;

(iii) The restricted reserves required by subsection 1(a) of this rule, if applicable; and

(iv) Any additional reserves for asset valuation contingencies or loss contingencies required by the Medicaid Agency pursuant to Alabama Medicaid Administrative Code Rule 560-X-64-.08 or otherwise required by applicable law.

(7) No ICN shall reduce its combined capital and surplus, by distribution of its assets to the members, owners, or risk-bearing participants of the ICN or otherwise, below the ICN's required capital and surplus under the rules of the Medicaid Agency.

(8) Each ICN shall at its expense procure and maintain, throughout the term of the risk contract between the Medicaid Agency and the ICN, professional and general liability insurance, directors' and officers' liability insurance, errors and omissions liability insurance, and, if the ICN provides Medicaid services to enrollees directly, medical malpractice insurance, in such amounts and including such coverage as set forth in the risk contract.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq*.
History: Emergency Rule filed and effective March 31, 2017. **Amended:** Filed June 9, 2017; effective July 24, 2017.

Rule No. 560-X-64-.07 Service Delivery Network Requirements for Integrated Care Networks

(1) Definitions - As referenced in this Chapter of the Alabama Medicaid Administrative Code the following terms shall be defined as follows:

(a) *Primary medical provider* (PMP) is defined as one of the following:
(i) Family Practitioner
(ii) Federally Qualified Health Center
(iii) General Practitioner
(iv) Internist
(v) Geriatrician
(vi) Obstetrician or Gynecologist
(vii) Pediatrician
(viii) Rural Health Clinic

(b) *Core Specialist* is defined as each of the following:
(i) Anesthesiologist
(ii) Cardiologist
(iii) Cardiovascular Surgeon
(iv) Endocrinologist
(v) Gastroenterologist
(vi) General Surgeon
(vii) Nephrologist
(viii) Neurologist
(ix) Oncologist
(x) Ophthalmologist
(xi) Optometrist
(xii) Orthopedic surgeon
(xiii) Psychiatrist
(xiv) Pulmonologist

(xv) Rheumatologist
(xvi) Urologist

(c) *Facility* is defined as each of the following:
(i) Hospitals as defined in Rule 560-X-7-.02
(ii) Psychiatric Facilities for Individuals 65 and Over
(iii) Outpatient Mental Health Center
(iv) Nursing Facility as defined in Rule 560-X-10-.01

(d) *Hospice Provider* is defined in accordance with Rule 560-X-51-.02(1) and which meets the requirements in Rule 560-X-51-.03.

(e) *Home and Community Based Service – Site-Based Services Provider* is defined as a provider of a 1915(c) waiver approved service to whom an enrollee must travel, in order to receive services.

(f) *Home and Community Based Service – In-Home Services Provider* is defined as a provider of a 1915(c) waiver approved service who travels to an enrollee's home, in order to provide services.

(g) *Non-Core Specialist* is defined as any medical provider type not listed above which is needed to appropriately service the Integrated Care Network ("ICN") enrollees and provide care delivery for all of the services and benefits covered by the ICN program.

(h) *Urban and Rural Counties* are defined in accordance with the Code of Federal Regulations 42 C.F.R. § 438.52(b)(3), which defines a rural area as any county designated as "micro," "rural, "or "County with Extreme Access Considerations (CEAC)" in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year.

(i) *Service Delivery Network* is defined as one that meets and maintains each of the following:

(i) Makes available and accessible all non-excluded services that are required under the State Plan and 1915(c) waiver(s) included in the ICN program, including those Covered Services identified by rule in the Alabama Medicaid Administrative Code and in the risk contract between the Medicaid Agency and the ICN.

(ii) Consists of a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all enrollees of the ICN. The following factors shall be considered in determining an appropriate provider network.

(A) The anticipated Medicaid enrollment in accordance with the state's standards for access to care;

(B) The expected utilization of services, taking into account the characteristics and health care needs of specific Medicaid populations represented in the particular ICN;

(C) The numbers and types of providers (in terms of training, experience, and specialization) required to furnish the contracted Medicaid services;

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

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

(F) The ability of Home and Community Based Service – In-Home Services Providers to provide in-home services outside of standard business hours, defined as Monday-Friday (excluding legal holidays), from 8AM to 5PM;

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

(H) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities;

(I) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions;

(J) The ability of network providers to provide the delivery of services in a culturally competent manner to all Medicaid enrollees in accordance with 42 C.F.R. § 438.206(c)(2).

(K) The ability of network providers to offer self-directed service options for enrollees who wish to self-direct eligible services, as defined by an approved 1915(j) waiver.

(iii) Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services.

(iv) Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

(v) Meets and requires its providers to meet the following state standards for timely access to care and services, taking into account the urgency of the need for services:

Appointment Availability	
Office Appointments	
Life-Threatening Emergency Care	Immediate
Urgent Care	24 hours
Routine Sick Care – PMP	3 calendar days of presentation or notification excluding legal holidays

Routine Sick Care – Core Specialist	30 calendar days of presentation or notification excluding legal holidays
Routine Well Care	90 calendar days (15 calendar days if pregnant)
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
Wait Times	
Office-based Appointments	
Walk-Ins	2 hours or schedule an appointment within the standards of appointment availability
Scheduled Appointment	1 hour
Life-Threatening Emergency	Immediate
Home and Community Based Services	
Site-Based Services	No greater than 1-hour difference between enrollee arrival and departure as scheduled and documented in the enrollee's person centered service plan.
In-Home Services	No greater than 1-hour difference between delivery of the service as scheduled and documented in the enrollee's person centered service plan.
Transportation Services	
Non-Emergency Transportation Services	Transportation scheduled so that the enrollee arrives on time for the appointment, but no sooner than 1 hour before the appointment; and no greater than 1 hour wait after the conclusion of the appointment for transportation home; and not be picked up prior to the completion of the appointment.

(vi) Establishes appropriate policies and procedures to regularly monitor providers and ensure compliance with the above listed accessibility standards. The policies and procedures shall require a correction action if there is a failure to comply.

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

Provider Type	Minimum Number	Distance
PMPs	1.5 per 1,000 non-dual eligible enrollees, with a minimum of two	50 miles from each non-dual eligible enrollee's residence
Core Specialists (for **each** of the types identified in section (1)(b) of this rule)	0.2 per 1,000 non-dual eligible enrollees	50 miles from each non-dual eligible enrollee's residence

Facilities (for **each** of the types identified in section (1)(c) of this rule) excluding Nursing Facilities as defined in Rule 560-X-10-.01	No requirement	50 miles from each enrollee's residence
Nursing Facilities as defined in Rule 560-X-10-.01	No requirement	25 miles from each enrollee's residence before entering the Nursing Facility who resides in an urban county, 50 miles from each enrollee's residence before entering the Nursing Facility who resides in a rural county
Hospice Provider as defined in Rule 560-X-51-.03 and which meets the requirements in Rule 560-X-51-.03	2 provider options per county	No requirement
Home and Community Based Service – Site-Based Services Provider (for the type identified in section (1)(e) of this rule)	2 provider options per county	25 miles from each enrollee's primary community residence who resides in an urban county, 50 miles from each enrollee's primary community residence who resides in a rural county
Home and Community Based Service – In-Home Services Provider (for type identified in section (1)(f) of this rule)	2 provider options per county	No requirement

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

(viii) Must have an adequate amount of Non-Core Specialists, as needed to appropriately service its enrollees and provide care delivery for all of the services and benefits covered by the ICN program.

(ix) Must have an adequate amount of Nursing Facilities as defined in Rule 560-X-10-.01, Hospice Providers as defined in Rule 560-X-51-.02(1) and which meet the requirements in Rule 560-X-51-.03, Home and Community Based Services – Site-Based Services Providers as defined in section (1)(e) of this rule, and Home and Community Based Services – In-Home Services Providers as defined in section (1)(f) of this rule, as required to appropriately service its enrollees, provide choice of providers to enrollees, and facilitate timely and effective care transitions and community participation.

(x) The ICN must establish agreements with the Alabama Department of Mental Health (ADMH) to ensure that each ICN establishes and maintains an adequate network of ADMH

certified behavioral health providers to appropriately address the needs of enrollees who have mental illnesses and substance abuse disorders. The ICN provider network must include ADMH-certified mental health and substance abuse providers.

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

(xii) Requires out-of-network providers to coordinate with the ICN with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

(2) Each entity selected via competitive procurement must demonstrate to the satisfaction of the Medicaid Agency that its Service Delivery Network meets the requirements of this rule based on the timelines established by the Medicaid Agency. An exception from the requirements of Service Delivery Network requirements as defined in this rule may be made, within the sole discretion of the Medicaid Agency, upon the request of an entity using an Agency approved form, or as otherwise deemed appropriate by the Medicaid Agency.

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

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

(ii) The exception the ICN is requesting;

(iii) Steps taken by the ICN to comply with requirement before requesting the exception;

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

(v) Description of the ICN's plan to adequately provide covered services if exception is granted.

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

(c) If the Agency grants an exception, the ICN must submit quarterly reports to the Agency detailing enrollee access to the provider type subject to the exception.

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

(e) An exception may be revoked earlier if the Agency determines, in its sole discretion, that the continuance of the exception is to the detriment of the enrollees or the circumstances have materially changed since the exception was granted.

(f) Each ICN must also submit documentation necessary to demonstrate that the ICN has the capacity to serve the expected enrollment in accordance with Medicaid standards for access to care under this rule at the time it enters into a full-risk contract with the Medicaid Agency and at any time there has been a significant change in the entity's operations that would affect capacity and services.

(3) Notwithstanding the minimum network requirements of this rule, Medicaid enrollees shall have the option to be treated at the nearest hospital or other facility able to provide the most appropriate medically necessary level of care in cases of medical emergency or necessity and/or when the treatment of a Medicaid enrollee elsewhere could pose an unreasonable risk of harm. For the purposes of this Subsection, medical emergency or necessity is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. A medical emergency or necessity is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

(4) Each ICN must ensure compliance with all requirements for the furnishing of Medicaid services in accordance with this rule, applicable laws and medical standards as well as the needs of Medicaid enrollees.

(5) The Medicaid Agency may inspect or request additional documentation and information relating to the documentation submitted pursuant to this rule at any time to verify the information contained therein.

(6) Notwithstanding any provisions of this rule to the contrary, any ICN shall be governed by federal access standards which may be found in their entirety in 42 C.F.R. §§ 438.206 - 438.210 and which are hereby incorporated by reference and made a part of this rule as if set out in full and all provisions thereof are adopted as rules of the Medicaid Agency.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq*; 42 C.F.R. § 438.68; 42 C.F.R. §§ 438.206 - 438.210.
History: Emergency rule filed and effective March 31, 2017. **Amended:** Filed June 9, 2017; effective July 24, 2017.

Rule No. 560-X-64-.08 Active Supervision of Organizations with Probationary Certification

(1) The Medicaid Agency shall actively monitor and supervise the collective negotiations, bargaining, contracting and cooperation among Collaborators as defined in Section 22-6-220(2) of the Alabama Code, and each organization that receives probationary certification as an Integrated Care Network (ICN) ("Probationary Organization") in accordance with the Alabama Medicaid Administrative Code. Each Probationary Organization shall submit an online periodic report to the Medicaid Agency quarterly on the last day of the month following the end of each full quarter (January 31, April 30, July 31 and October 31) in which the Probationary Organization is certified.

(2) Each periodic report must contain the information requested by the Medicaid Agency in order to allow the Medicaid Agency to engage in appropriate state supervision in accordance with Section 22-6-233 of the Alabama Code, including the following information:

(a) A description of the Probationary Organization's activities during the reporting period, including a description of what entities and persons with whom the Probationary Organization engaged in collective negotiations, bargaining, contracting or cooperation during the reporting period;

(b) A description of progress the Probationary Organization has made during the reporting period establishing or developing an ICN that may gain full ICN certification on or before the date specified in Section 22-6-231(a)(3) of the Alabama Code;

(c) A description of any concerns or problems encountered in the collaborative process during the reporting period; and

(d) A description of the nature and scope of expected future activities of the Probationary Organization.

(3) At least annually, each Probationary Organization must also include a narrative analysis, based upon currently available information, explaining whether and how the operation of the organization as a certified ICN is expected to:

(a) result in improved quality of services to Medicaid beneficiaries;

(b) result in cost-containment in providing applicable Medicaid services;

(c) result in enhancements in technology;

(d) maintain competition in the health care services market; and/or

(e) identify appropriate service delivery systems and reimbursement methods in order to align incentives in support of integrated and coordinated health care delivery consistent with Sections 22-6-220, *et seq*. of the Alabama Code.

(4) The Probationary Organization shall certify in each periodic report that the bargaining, negotiations, contracting and cooperation during the reporting period were in good faith and necessary to meet the legislative intent expressed in Section 22-6-233 of the Alabama Code.

(5) The Probationary Organization's submittal of a periodic report in accordance with this rule does not relieve any person or entity from the requirement to submit periodic progress reports to the Medicaid Agency pursuant to a Certificate to Collaborate under Alabama Medicaid Administrative Code Rule 560-X-64.-02.

(6) In addition, the Medicaid Agency may inspect or request additional information, inspect or request documentation, and may convene meetings, make inquiries, and/or have such discussions it deems appropriate.

(7) All documents and information produced or provided by the Probationary Organization or third parties and all notes, memoranda, emails, correspondence, reports, work papers, findings, documents or other information generated by the Medicaid Agency as part of any audit, investigation, inspection or request for additional documents or information may be withheld from public inspection or disclosure if necessary, in the opinion of the Commissioner of the Medicaid Agency, to protect the confidential or proprietary nature of such information and documents or if deemed necessary to protect the Probationary Organization and any persons affiliated therewith from unwarranted injury or if otherwise deemed by the Commissioner of the Medicaid Agency to be in the public interest.

(8) Failure to file a periodic report required by this rule or failure to provide information or documents requested by the Medicaid Agency within fourteen (14) days after notice of default shall result in a fine of $100 for each additional day that the periodic report is not filed or the requested information or documents are not provided to the Medicaid Agency. In addition, the Medicaid Agency may revoke a Probationary Certificate as an Integrated Care Network for failure to file a periodic report required by this rule or failure to provide information or documents requested by the Medicaid Agency within fourteen (14) days after notice of default.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq.*
History: Emergency Rule filed and effective March 31, 2017. **Amended:** Filed June 9, 2017; effective July 24, 2017.

Rule No. 560-X-64-.09 - Qualification Criteria for Participation in the Mandated Competitive Procurement for Integrated Care Networks

(1) To initiate the state mandated competitive procurement ("MCP") for the services of one or more integrated care networks ("ICN") pursuant to Section 22-6-231 of the Alabama Code, the Medicaid Agency will release the MCP on a date to be established in writing by the Medicaid Agency (the "MCP Release Date").

(2) The Medicaid Agency will score responses from Qualified Entities. Responses submitted by entities which are not Qualified Entities shall be rejected by the Medicaid Agency. A Qualified Entity is one that meets all of the following criteria:

(a) Submits an application for Probationary Certification as an integrated care network ("Probationary Certification") in accordance with Alabama Medicaid Administrative Code on or before the date set by the Medicaid Agency.

(b) Obtains a Probationary Certification in accordance with, and on or before the date established in, Alabama Medicaid Administrative Code and holds that Probationary Certification at the time responses to the MCP are due;

(c) Has attended all meetings and training sessions which the Medicaid Agency deems, in writing, to be mandatory; and

(d) Complies with all other qualification requirements contained in the MCP, or any other regulation or policy of the Medicaid Agency which applies to organizations with Probationary Certification as an integrated care network.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-231.
History: New Rule: Filed August 11, 2017; effective September 25, 2017.

Rule No. 560-X-64-.10 – Financial Reporting and Audit Requirements

(1) Each integrated care network ("ICN") shall provide to the Medicaid Agency a periodic financial report setting forth information concerning the ICN's restricted reserves, capital and surplus, and such other information as the Medicaid Agency may require, in such form and content and at such frequency as may be prescribed by the Medicaid Agency from time to time. In addition, each ICN shall provide such other financial reports and information as may be required by the Medicaid Agency pursuant to applicable state and federal laws and regulations. The Medicaid Agency may require that ICNs use specific reporting forms in order to supply required information.

(2) Each ICN shall report all data as required by the Medicaid Agency, consistent with the federal Health Insurance Portability and Accountability Act (HIPAA) as in effect from time to time.

(3) After there is any change in the financial condition of an ICN which could result in a determination of hazardous financial condition or insolvency pursuant to Rule 560-X-64-.11, including but not limited to any deficiency in the required restricted reserves or capital and surplus of the ICN, the ICN shall promptly give notice to the Medicaid Agency describing the circumstances of such change and its plan of action for responding to the change. Notwithstanding any such plan of action, the Medicaid Agency may at any time take any action or exercise any authority, right, or remedy available in accordance with the rules of the Medicaid Agency, the risk contract, or applicable law in connection with such change in the financial condition of the ICN.

(4) Each ICN shall at its expense have its independent certified public accountant deliver directly to the Medicaid Agency the certified audited annual financial statements of the ICN, prepared in accordance with Generally Accepted Accounting Principles (GAAP) and generally accepted auditing standards (GAAS), no later than one hundred twenty (120) calendar days after the ICN's fiscal year end, for the immediately preceding fiscal year. The Medicaid Agency may require that supplemental financial information be included in the ICN's audited financial statements related to restricted reserves, capital and surplus, and other related information. A statement shall be included with the audit report delivered by the ICN's accountant acknowledging that the Medicaid Agency is an intended beneficiary of the audit report.

(5) In addition to the annual audits conducted by the ICN's independent certified public accountant, the Medicaid Agency shall conduct or contract for audits of each ICN, in accordance with Section 22-6-226(c)(5) of the Alabama Code, as often as the Medicaid Agency deems necessary or appropriate, but at least every three years.

(a) The audits shall be conducted for the purposes of determining the financial condition of the ICN, its means and ability to fulfill its obligations, the nature of its operations, and/or its compliance with applicable provisions of the risk contract, rules of the Medicaid Agency, and other applicable state and federal laws and regulations, including but not limited to a review of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by or on behalf of the ICN.

(b) When the Medicaid Agency determines that an audit should be conducted, the Medicaid Agency shall appoint one or more auditors to perform the audit and instruct them as to the scope of the audit. The Medicaid Agency may adopt or prescribe such audit guidelines and procedures as the Medicaid Agency from time-to-time determines to be appropriate.

(c) The Medicaid Agency may retain appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as needed to conduct an audit. The reasonable cost of retaining such professionals and specialists, and all other reasonable costs of the audit as determined by the Medicaid Agency including transportation and travel expenses, shall be borne by the ICN that is the subject of the audit.

(d) The ICN shall produce or provide timely, convenient, and free access at all reasonable business hours at the offices of the ICN to all books, records, accounts, papers, documents and electronic and other recordings (hereafter collectively referred to in this rule as "books and records") in its possession or control relating to the matter under audit, including as applicable the property, assets, business and affairs of the ICN. The officers, directors, and agents of the ICN shall facilitate the audit.

(e) An audit report shall be issued with respect to each audit of an ICN, as follows:

(i) Not later than sixty (60) calendar days after completion of an audit, the auditor in charge of the audit shall submit to the Medicaid Agency a written report of the audit, verified by the oath of the auditor. The audit report shall comprise only information appearing upon the books and records of the ICN, its agents, affiliates, or other persons being examined or information from testimony of individuals concerning the affairs of the ICN, together with such conclusions and recommendations as reasonably may be warranted from such information.

(ii) The Medicaid Agency shall make a copy of the audit report submitted under this section available to the ICN that is the subject of the audit and shall give the ICN an opportunity to review and respond to the audit report. The Medicaid Agency may request additional information or meet with the ICN for the purpose of resolving questions or obtaining additional information, and may direct the auditor to consider the additional information for inclusion in the audit report. The Medicaid Agency may issue the report as a final audit report after the ICN has had an opportunity to review and respond to the report.

(iii) If the final audit report reveals that the ICN has violated or is operating in violation of any provision of the risk contract, rule of the Medicaid Agency, or any other applicable state or federal law or regulation, the Medicaid Agency may order the ICN to take any action the Medicaid Agency considers necessary and appropriate to cure such violation and to take such additional actions and measures as may be permitted under the rules of the Medicaid Agency or any other applicable law or regulation.

(iv) A report filed as a final audit report is subject to public inspection.

(f) Nothing in this rule shall be interpreted to require the Medicaid Agency to conduct an audit, issue an audit report, or wait any period of time before taking any action or exercising any authority, right, or remedy available to the Medicaid Agency under the rules of the Medicaid Agency, the risk contract, or applicable law.

(6) In addition to any other powers of the Medicaid Agency relating to the audits of ICNs, the Medicaid Agency may at any time require any ICN to produce such books and records in the possession of the ICN or its affiliates or risk-bearing participants as are reasonably necessary to ascertain the financial condition of the ICN or to determine compliance with the rules of the Medicaid Agency and the contract between the ICN and the Medicaid Agency. If the ICN or its affiliates or risk-bearing participants fails to comply with any such request within the period of time prescribed the Medicaid Agency, the Medicaid Agency may audit the ICN and its affiliates or risk-bearing participants to obtain such books and records, in addition to imposing sanctions or other remedies under the rules of the Medicaid Agency and/or the contract between the ICN and the Medicaid Agency. The Medicaid Agency shall report the failure to comply to all of the ICN's participating providers. The ICN shall pay the costs incurred by the Medicaid Agency.

(7) In accordance with 42 C.F.R. § 438.66, the Medicaid Agency has the authority to monitor the ICN's operations, including, at a minimum, operations related to violations of the conditions for federal financial participation, as set forth in subpart J of 42 C.F.R. § 438.

(8) The ICN must report information related to the ICN’s medical loss ratio (“MLR”) as required by 42 C.F.R. § 438.8.

(a) The ICN shall calculate its MLR according to the requirements in 42 C.F.R. § 438.8 and shall report to the Medicaid Agency the ICN’s MLR no later than twelve (12) months after the completion of each rate year the ICN provides services to enrollees pursuant to a risk contract. The ICN’s report on its MLR must include the following information:

(i) Total incurred claims;

(ii) Expenditures on quality improving activities;

(iii) Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1)-(5), (7), (8), and (b);

(iv) Non-claims costs;

(v) Premium revenue;

(vi) Taxes, licensing and regulatory fees;

(vii) Methodology(ies) for allocation of expenditures;

(viii) Any credibility adjustment applied;

(ix) The calculated MLR;

(x) Any remittance owed to the State, if applicable;

(xi) A comparison of the information reported in this paragraph with the audited financial report required under section (4) of this rule and 42 C.F.R. § 438.3(m);

(xii) A description of any aggregation method used under 42 C.F.R. § 438.8(i); and

(xiii) The number of member months.

(b) In accordance with 42 C.F.R. § 438.8(m), in any instance where the Medicaid Agency makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the Medicaid Agency, the ICN shall recalculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the requirements of subsection (8)(a) of this rule and 42 C.F.R. § 438.8(k).

(c) The ICN shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the ICN within one hundred eighty (180) calendar days of the end of the MLR reporting year or within thirty (30) calendar days of being requested by the ICN, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of the MLR reporting.

(d) The ICN must attest to the accuracy of the MLR calculation in accordance with the requirements of 42 C.F.R. § 438.8 when submitting the report required under subsection (8)(a) of this rule and 42 C.F.R. § 438.8(k), including a new report submitted under subsection (8)(b).

(9) The Medicaid Agency, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the ICN or its subcontractors,

and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit exists for ten (10) years from the final date of the risk contract term, including any extensions, or from the date of completion of any audit, whichever is later.

(10) Except as otherwise determined by the Medicaid Agency or required by applicable law, all financial reports submitted to the Medicaid Agency pursuant to this rule shall be public records subject to disclosure.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 et seq. 42 C.F.R. Part 438.
History: New Rule: Filed August 11, 2017; effective September 25, 2017.

Rule No. 560-X-64-.11 – Hazardous Financial Condition and Insolvency

(1) An integrated care network ("ICN") shall be deemed to be in a hazardous financial condition if the continued operation of the ICN is determined by the Medicaid Agency to be hazardous to the ICN's enrollees, participating providers, or the State. The Medicaid Agency may in its discretion consider any factor or finding determined by the Medicaid Agency to be hazardous to enrollees, participating providers, or the State to determine whether an ICN is in a hazardous financial condition, including but not limited to one or more of the following factors:

(a) Nonpayment or recurring delinquency in the ICN's payments to providers;

(b) Adverse findings reported in financial condition examination reports, audit reports, or actuarial opinions, reports or summaries;

(c) Whether the ICN has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the ICN, when considered in light of the assets held by the ICN with respect to such reserves and related actuarial items including but not limited to the investment earnings on such assets, and the considerations anticipated to be received and retained under such contracts;

(d) Whether the ICN's operating losses in the last 12-month period or any shorter period of time is greater than 50 percent of the ICN's remaining capital and surplus in excess of the minimum required;

(e) Whether a risk-bearing participant which has contributed cash, capital, or other assets to the ICN, or a guarantor, surety, insurer, obligor, or any entity that has a direct or indirect ownership interest in a risk-bearing participant which has contributed cash, capital, or other assets to an ICN, is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations and which, in the opinion of the Medicaid Agency, may affect the solvency of the ICN, or whether a risk-bearing participant has terminated or stated its intent to terminate its relationship with the ICN as a risk-bearing participant;

(f) Contingent liabilities, pledges or guaranties that either individually or collectively involves a total amount that, in the opinion of the Medicaid Agency, may affect the solvency of the ICN;

(g) An adverse change in the age and collectability of receivables other than from the Medicaid Agency;

(h) Whether the management of an ICN, including officers, directors or any other person who directly or indirectly controls the operation of the ICN, fails to possess and demonstrate the competence, fitness and reputation determined by the Medicaid Agency to be necessary to serve the ICN in such position;

(i) Whether management of an ICN has failed to respond properly to inquiries relating to the condition of the ICN or has furnished false and misleading information concerning an inquiry;

(j) Whether the ICN has failed to meet financial responsibility, accountability or filing requirements in the absence of a reason satisfactory to the Medicaid Agency;

(k) Whether management or any other agent of an ICN either has filed a false or misleading sworn financial statement or has released a false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the ICN;

(l) Whether the ICN has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

(m) Whether the ICN has experienced or there is sufficient evidence that the ICN will likely experience in the foreseeable future cash flow or liquidity problems, or both;

(n) Whether management has established reserves that do not comply with minimum standards established by state laws, regulations, accounting standards, sound actuarial principles and standards of practice;

(o) Whether transactions among affiliates, subsidiaries or controlling persons for which the ICN receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the ICN's ability to meet its outstanding obligations as they mature;

(p) Any significant monetary judgment or fine filed against the ICN or any significant civil or criminal action brought against or concluded adversely to the ICN; and

(q) For organizations that are not incorporated as a nonprofit, whether the ICN's acute medical care service claims exceed the Medicaid Agency's projected amount of acute medical care dollars within the capitation rates subject to fees or taxes assessed pursuant to 26 C.F.R. § 57.1, *et. seq*.

(2) For the purposes of making a determination of the financial condition of an ICN under these rules or the ICN's contract with the Medicaid Agency, the Medicaid Agency may in its discretion do one or more of the following:

(a) Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates; and

(b) Increase the ICN's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the ICN will be called upon to meet the obligation undertaken within the next 12-month period.

(3) In addition to the other requirements that the Medicaid Agency may impose and actions that the Medicaid Agency may take under the rules of the Medicaid Agency, the risk contract between the ICN and the Medicaid Agency, and applicable state and federal law, if the Medicaid Agency determines that an ICN is in a hazardous financial condition, the Medicaid Agency may in its discretion require the ICN to do one or more of the following:

(a) Reduce, suspend or limit the volume of business being accepted or renewed;

(b) Increase the capital and surplus of the ICN above the level required by Rule 560-X-64-.06;

(c) Increase the restricted reserves of the ICN above the level required by Rule 560-X-64-.06;

(d) Suspend or limit distributions and any other payments to members, risk-bearing participants, and other related persons and entities of the ICN, other than payments to providers for covered services;

(e) Limit or withdraw from certain investments or discontinue certain investment practices if and to the extent the Medicaid Agency determines such action is necessary;

(f) File reports in a form acceptable to the Medicaid Agency concerning the market value of the ICN's assets;

(g) In addition to regular annual statements and such other financial statements as may be required by the Medicaid Agency, file interim reports regarding financial and other matters on a form specified by the Medicaid Agency;

(h) Correct corporate governance practice deficiencies, and adopt and utilize the governance practices acceptable to the Medicaid Agency; and

(i) Provide a business plan to the Medicaid Agency demonstrating the corrective actions the ICN will take to improve its financial condition and a schedule for taking such actions.

(4) An ICN shall be deemed to be insolvent when such organization is not possessed of admitted assets at least equal in value to the sum of all its liabilities and minimum capital and surplus required by Rule 560-X-64-.06 or this rule and the Medicaid Agency declares that the ICN is insolvent. If the Medicaid Agency determines that an ICN is insolvent, the Medicaid Agency shall give notice of the insolvency to all of the ICN's participating providers.

(5) If and when the Medicaid Agency determines from any information, report, document or statement made to the Medicaid Agency or from any audit conducted or contracted for by the Medicaid Agency that an ICN is insolvent, the Medicaid Agency may in its discretion do one or more of the following:

(a) Immediately proceed to terminate the risk contract between the Medicaid Agency and the ICN;

(b) Allow the ICN a period of time in which to cure the deficiency with cash or authorized investments; provided that if such deficiency is not cured within the time prescribed, the Medicaid Agency may proceed to terminate the risk contract between the Medicaid Agency and the ICN; and

(c) Exercise any other remedy provided by the risk contract between the Medicaid Agency and the ICN or applicable law.

(6) The ICN shall be responsible for continuation of services to enrollees during insolvency, for the duration of the period for which payment may be due to providers for covered services.

(7) If the Medicaid Agency determines that an ICN is insolvent, is in a hazardous financial condition, or is otherwise in default under the risk contract between the Medicaid Agency and the ICN, the Medicaid Agency may, in addition to its other rights and remedies, access and disburse the ICN's restricted reserves for the payment of providers in accordance with terms of the Model Depository Agreement provided by the Medicaid Agency and/or draw upon any letter of credit provided by the ICN pursuant to 560-X-64-.06.

(8) No enrollee shall be liable for any of the following:

(a) The ICN's debts, in the event of the ICN's insolvency;

(b) Covered services provided to the enrollee, for which the Medicaid Agency does not pay the ICN;

(c) Covered services provided to the enrollee, for which the Medicaid Agency or the ICN does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; and

(d) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the ICN provided the services directly.

(9) The Medicaid Agency may exercise authority under this rule in addition to or in lieu of any other authority that the Medicaid Agency may exercise under other rules promulgated by the Medicaid Agency, other applicable state and federal laws and regulations, or the risk contract between the Medicaid Agency and the ICN, including without limitation calling for payment under any letter of credit securing the ICN's performance of the risk contract, in accordance with the terms thereof. Without limiting the foregoing, the Medicaid Agency may impose any of the sanctions described in 42 CFR §§ 438.700-438.708, as in effect from time to time, in accordance with the provisions thereof and consistent with the risk contract and rules promulgated by the Medicaid Agency, including the appointment of temporary management for the ICN if the Medicaid Agency has made a finding described in 42 CFR § 438.706 permitting or requiring the imposition of temporary management.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 et seq. 42 C.F.R. Part 438.

History: New Rule: Filed August 11, 2017; effective September 25, 2017.

Rule No. 560-X-64-.12 Probationary Certification of Organizations Seeking to Become Integrated Care Networks

(1) An organization may receive probationary certification as an integrated care network (Probationary Certification) upon submission of an application to the Medicaid Agency that satisfies the requirements of this rule.

(2) An organization seeking Probationary Certification shall be organized or incorporated under Alabama law in a manner consistent with the accomplishment of its stated mission which shall include, as a minimum, delivery of medical care and long-term health care services in accordance with Sections 22-6-220, *et seq*. of the Alabama Code. For as long as the health insurance providers fee under 26 C.F.R. Part 57 is effective, organizations incorporated as a nonprofit corporation shall mandate in their Certificate of Formation of the organization that:

(a) no part of the organization's net earnings shall inure to the benefit of any private shareholder or individual, no substantial part of the activities of the organization shall include carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and the organization shall not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office; and

(b) more than 80 percent of the gross revenues of the organization shall be received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act.

(3) An organization seeking Probationary Certification must have a governing board of directors acceptable to the Medicaid Agency that, in the sole discretion of the Medicaid Agency, meets or substantially meets the requirements of Section 22-6-221(d) of the Alabama Code and Alabama Medicaid Administrative Code Rule 560-X-64-.03. For the purposes of this rule, whether an organization "substantially meets" the aforementioned requirements will be determined by the Medicaid Agency, in its sole discretion, on a case by case basis. However, an organization seeking Probationary Certification should have at least a majority of the required number of directors including at least as a majority of both risk bearing and non-risk bearing directors in place at the time it applies for Probationary Certification. Such organization shall also provide the Medicaid Agency copies of all or substantially all documents set forth in subsection (6)(g), with minutes reflecting board approval. The Medicaid Agency may for good cause, as determined in the sole discretion of the Medicaid Agency, allow an organization additional time to make certain appointments and/or provide documents required in this rule. Should Probationary Certification be granted to an organization that has not fully met the aforementioned requirements, the organization will be required to provide a corrective action plan, satisfactory to the Medicaid Agency, describing how the organization will satisfy such requirements and to fully meet those requirements within the time required by the Medicaid Agency or the Probationary Certification will be terminated.

(4) The Medicaid Agency shall have power to approve the members of the governing board of the organization and the board's structure, powers, bylaws, or other rules of procedure, as well as all amendments thereto. No organization shall be granted Probationary Certification without approval.

(5) All applications for Probationary Certification must be submitted to the Medicaid Agency on or before the date set by the Medicaid Agency. The Medicaid Agency shall have the power, at its sole discretion, to permit an applicant to supplement its application to the Medicaid Agency.

(6) All applications for Probationary Certification must include the following information or documentation for the Medicaid Agency's review and approval:

(a) The organization's name, physical and mailing address, email address, and telephone number;

(b) The name, mailing address, email address, and telephone number of the organization's registered agent and each person authorized by the organization to receive notices and communications relating to the organization's application;

(c) The name, mailing address, and telephone number of the primary person whom the Medicaid Agency should contact concerning any questions or issues relating to the organization's application;

(d) A proposed organizational chart identifying the relationship among the members of the board of directors, officers, controlling persons, owners, participants, and administrators of the organization and any other persons responsible for the medical care and services of the organization, as applicable;

(e) The applicant's applicable National Provider Identifier (NPI) number(s), Medicaid ID number(s), Taxpayer Identification Number(s) (TIN), and any state professional or facility license number(s);

(f) Identification of the organization's Certificate to Collaborate Number issued by the Medicaid Agency;

(g) Copies of any organizational, governing, and operational documents which may exist such as the applicant's articles of incorporation, bylaws, operating agreement, certificate of formation, rules, trust agreements, organizational minutes and/or minutes appointing or designating persons as officers, directors, managers, resolutions, confidentiality agreements, conflict of interest policies, management agreements, administrative service agreements, loan agreements, material contracts or other documents creating an executive committee or other committee and/or appointing members thereto and all other similar or applicable documents and agreements regulating the conduct of the internal affairs of the applicant and all amendments thereto; and

(h) A proposed plan for creating a citizens' advisory committee that meets the requirements of Section 22-6-222 of the Alabama Code and Alabama Medicaid Administrative Code Rule 560-X-64-.04, including, but not limited to, the organization's plan for identifying and recruiting committee members and holding initial meetings of its citizens' advisory committee. The applicant shall provide periodic updates to the Agency on its progress in developing a citizens' advisory committee.

(7) All applications for Probationary Certification shall also include the following information concerning the organization's governing board of directors for the Medicaid Agency's review and approval:

(a) The name, business, occupation or medical specialty, mailing address, email address and telephone number of each board of directors member;

(b) The National Provider Identifier (NPI) number(s), Medicaid ID number(s), Taxpayer Identification Number(s) (TIN), Social Security Number(s) (SSN), Certificate to Collaborate Number(s), and any state professional or facility license number(s) of each board of directors member, as applicable;

(c) Documentation and information demonstrating the proposed amounts, levels and types of financial risk of all risk-bearing participants and directors of the organization;

(d) Information evidencing that the memberships of the board of directors and any executive committee are inclusive and reflective of the gender, race, and geographical areas makeup of the population to be served;

(e) With respect to each board of directors member, identification whether each individual:

(i) is a risk-bearing participant or represents a risk-bearing participant in the organization as described in Section 22-6-221(d)(1)a. of the Alabama Code and Alabama Medicaid Administrative Code Rule 560-X-64-.03 and the nature of his/her participation as a risk-bearing participant;

(ii) is not a risk-bearing participant and is not an employee or representative of a risk-bearing participant in the organization, and meets the other requirements set forth in Section 22-6-221 of the Alabama Code. If the board of directors member is appointed by one of the associations or organizations identified in Alabama Medicaid Administrative Code 560-X-64-.03(1)(b), the applicant shall provide correspondence from such association or organization confirming such appointment.

(f) With respect to each board of directors member, as applicable, background information pertaining to any adverse action against any occupational, professional or vocational license or permit; criminal offenses other than civil traffic offenses; civil judgments involving dishonesty, breach of trust, or foreclosure; and any bankruptcy proceeding.

(g) Certification that a majority of the board of directors members do not and will not represent a single provider.

(h) Certification that each provider on the board of directors meets licensing requirements set by law, has a valid Medicaid provider number and is not disqualified from participating in Medicare or Medicaid.

(i) Information describing the experience and expertise of members of the board of directors in the delivery of required services and care.

(8) The governing body of an organization granted Probationary Certification shall be responsible for the establishment and oversight of its business and affairs. The organization may, by resolution of the governing body, delegate power and authority as permitted by Alabama law. Any such delegation shall include only the authority specifically delegated. The responsibilities of the governing body of the organization shall include, but not be limited to, the following:

(a) Adoption and enforcement of all policies governing the organization's management and delivery of all required services and care, quality improvement and utilization review programs including biannual meetings at a minimum for the purpose of evaluation and improvement of all required services and care of the organization and to implement the quality measures adopted by the ICN Quality Assurance Committee;

(b) The governing body shall keep minutes of meetings and other records to document the fact that the governing body is effectively discharging the obligations of its office regarding all required services and care. All records must be maintained for not less than ten (10) years;

(c) Assurance that the organization complies with applicable laws and regulations.

(9) All applications for Probationary Certification shall include a certification by the organization that all information entered on the application is true to the best of the organization's knowledge, and:

(a) that all bargaining, negotiation, contracting and cooperation in the creation of the organization has been and will continue to be in good faith;

(b) that such bargaining, negotiation, contracting and cooperation has been and will continue to be necessary to identify appropriate service delivery systems and reimbursement methods in order to align incentives in support of integrated and coordinated health care delivery;

(c) that such bargaining has been and will continue to be necessary to provide quality health care at the lowest possible cost to Alabama citizens who are Medicaid eligible;

(d) that the organization is not an entity that must be excluded from contracts as a condition for federal financial participation pursuant to 42 C.F.R. §438.808;

(e) that the organization does not have a prohibited affiliation with any individual debarred by a federal agency within the meaning of 42 C.F.R. §438.610;

(f) that each risk-bearing participant has the financial ability and solvency to satisfy his/her obligations as a risk-bearing participant; and

(g) that the applicant intends to provide all required services and care to Medicaid beneficiaries statewide.

(10) The Medicaid Agency may inspect or request additional documentation and information from an applicant and from members or proposed members of the board of directors as the Medicaid Agency deems appropriate before Probationary Certification or at any other time to verify that the Medicaid laws are implemented in accordance with the legislative intent.

(11) The Medicaid Agency may conduct meetings and conferences with an applicant or its existing or proposed governing board members as the Medicaid Agency deems appropriate before certification of a probationary integrated care network or at any other time to verify that the Medicaid laws are implemented in accordance with legislative intent. In addition to discussing information provided in the application, plans for establishing an adequate service delivery network, potential funding sources, organizational issues, and other topics may be discussed.

(12) The Medicaid Agency shall review the application and any additional documentation and information and, if the Medicaid Agency in its sole discretion determines that the applicant meets or substantially meets the requirements for probationary certification, the Medicaid Agency shall issue the organization a Probationary Certificate as an integrated care network. The applicant must meet or substantially meet, as determined by the Medicaid Agency in its sole discretion, the requirements for probationary certification on or before October 1, 2017, or such later date determined by the Medicaid Agency.

(13) The Medicaid Agency may require an organization that has been issued a Probationary Certificate as an integrated care network to take additional or corrective action with respect to any requirement of this rule. Failure to take such additional or corrective action to the satisfaction of the Medicaid Agency may lead to revocation of the organization's Probationary Certificate.

(14) A Probationary Certificate as an integrated care network shall be effective immediately upon issuance by the Medicaid Agency and shall expire no later than the date specified in Section 22-6-231(a)(3) of the Alabama Code. The issuance of a Probationary Certificate as an integrated care network provides no presumption that an organization shall be certified as an integrated care network.

(15) The holder of a Probationary Certificate as an integrated care network (Certificate Holder) shall promptly notify the Medicaid Agency of any substantial or material corrections or updates to the information provided in connection with the Certificate Holder's application. The Certificate Holder shall also promptly notify the Medicaid Agency of any vacancy and subsequent filling of any vacancy on the governing board of directors. The Medicaid Agency may revoke a

Probationary Certification upon a finding that the organization no longer meets the requirements for Probationary Certification.

(16) All applications submitted pursuant to this rule, all Probationary Certificates as an integrated care network, and the names and addresses of all applicants and their officers, directors and contact persons to whom the Medicaid Agency issues Probationary Certificates as an integrated care network shall be public records and shall be subject to disclosure. The applicant shall submit to the Medicaid Agency one original application and one copy from which information may be redacted for which the applicant has legal authority or a good faith basis to assert that such information is confidential, personal and/or proprietary. The Medicaid Agency may, in its sole discretion, treat documents and information submitted in connection with the application as confidential and not subject to disclosure.

(17) Any person or entity may notify the Medicaid Agency of conduct that is alleged to violate any of the certifications by the Certificate Holder or the board member pursuant to this rule. The notice must be signed, in writing and include a statement of facts supporting the allegation or violation. Upon receipt of such notice or upon receipt of such information obtained by the Medicaid Agency on its own, the Medicaid Agency shall review the notice and conduct any inquiry it finds appropriate and may refer the allegation of the violation to the State of Alabama Attorney General. The Medicaid Agency may also revoke a Probationary Certificate as an integrated care network upon finding that the Certificate Holder or the board of directors member has violated any of the certifications by the Certificate Holder or the board of directors member pursuant to this rule or it may in its discretion impose additional terms and conditions determined necessary to effectuate the objectives of Probationary Certification.

(18) Whenever an application for probationary certification as an integrated care network that was submitted to the Medicaid Agency on or before the date established in subsection (5) of this rule is denied or a Probationary Certificate as an integrated care network is terminated, the applicant or Certificate Holder will be afforded an opportunity for a hearing and rights of review in accordance with the requirements for contested case proceedings under the Alabama Administrative Procedure Act, Sections 41-22-1, *et seq*. of the Alabama Code.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-150, *et seq*.
History: Emergency Rule filed and effective June 23, 2017.

Rule No. 560-X-64-.13 Conflict of Interest Policy for Directors and Officers of Integrated Care Networks – NEW RULE

(1) An organization seeking to become fully certified as an integrated care network (ICN) or seeking to become an organization with probationary ICN certification shall adopt a conflict of interest policy for directors and officers. The conflict of interest policy shall require all directors and officers to conduct their activities as directors or officers so that they do not advance or protect their own interests, or the interests of others with whom they have a private or professional relationship, in a way that is detrimental to the interests of, or to, the ICN or organization with probationary ICN certification, and the conflict of

interest policy shall provide for the removal of any director or officer whose conduct violates such policy, unless a remedial action shall be sufficient to bring the director or officer into compliance with the policy. The conflict of interest policy shall require each director and officer to disclose in a written statement all employments, associations, commitments and financial interests that may currently exist or may have previously existed within the preceding two (2) years or that they reasonably expect to arise in the future, on the part of the director or officer, or his or her immediate family member, including spouse, dependents, adult children and their spouses, parents, spouse's parents, siblings and their spouses, that could reasonably be perceived, directly or indirectly, as a conflict of interest with the ICN or organization with probationary ICN certification. The statement shall also disclose whether the director or officer or his or her immediate family member as described in the preceding sentence is a current or former employee of, consultant with, or lobbyist for the Medicaid Agency or with any individual or entity (including subcontractors) providing enrollment broker or choice counseling services on behalf of the Medicaid Agency. Each director and officer shall file such disclosure statement with the ICN's or organization's board of directors and the Medicaid Agency on an annual basis.

(2) The conflict of interest policy must also:

(a) Require each director or officer to disclose relevant financial interests and potential conflicts of interest

(b) Provide a procedure satisfactory to the Medicaid Agency to determine whether an actual or potential conflict of interest exists and set forth a process satisfactory to the Medicaid Agency to address any potential conflicts of interest that arise;

(c) Address remedial action for directors or officers that fail to comply with the policy; and

(d) Require that the board of directors of the organization be responsible for enforcement of the conflict of interest policy and maintain minutes, disclosures of potential conflicts and other related documents, which will be subject to review by the Medicaid Agency, describing potential conflicts of interests and the action taken by the directors.

(3) An ICN and an organization with probationary ICN certification and each of its directors and officers must complete and submit to the Medicaid Agency the Disclosure Statement required by Act 2001-955 prior to the ICN entering into a contract with the Medicaid Agency.

(4) All current and former employees and agents of the Medicaid Agency who have responsibilities relating to contracts with an ICN or an organization with probationary ICN certification must comply with applicable provisions of the state ethics laws including, but not limited to, Sections 36-25-5, -7, -8, -11, -12, and -13 of the Alabama Code.

(5) An ICN and each of its directors and officers must observe the independence and freedom from conflict of interest requirements of 42 C.F.R. § 438.810(b)(1) and (2) in connection with any enrollment broker services that may be provided.

(6) No individual or entity of any kind shall have a direct or indirect ownership interest in more than one ICN. No individual or entity of any kind that has a direct or indirect ownership interest in an ICN may enter into an administrative and/or managerial contract or subcontract relating to another ICN.

(7) The Medicaid Agency may require an ICN or an organization with probationary ICN certification and each of its directors and officers to comply with additional conflict of interest requirements and policies the Medicaid Agency determines to be necessary to satisfy State and Federal requirements or necessary to address issues of noncompliance with the requirements of this Conflict of Interest Rule.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 et seq.
History: Emergency Rule filed and effective August 21, 2017. **Amended:** Filed August 21, 2017

Rule No. 560-X-64-.14 Right to Terminate Certificates of Probationary and Fully Certified Integrated Care Networks – NEW RULE

(1) The certificate of an organization as a probationary or fully certified integrated care network (referred to hereafter in this rule as “certificate”) may be terminated by the Medicaid Agency, in its sole discretion, for nonperformance of contractual duty or for failure to meet or maintain benchmarks, standards, or requirements provided by Sections 22-6-220, *et seq.* of the Alabama Code or rules promulgated by the Medicaid Agency.

(2) In the event the Medicaid Agency seeks to terminate a certificate, a written notice of termination shall be sent to the probationary or fully certified integrated care network (for the purposes of this rule hereafter collectively referred to as the “ICN”).

(3) The Medicaid Agency may terminate a certificate if the ICN fails to maintain the requirements for probationary certification as outlined in Alabama Medicaid Administrative Code Rule 560-X-64-.12.

(4) The Medicaid Agency may terminate a certificate if the ICN fails to meet the qualification criteria established in Rule 560-X-64-.09, fails to submit a response to the Medicaid Agency’s Mandated Competitive Procurement (MCP), does not have its response selected for Readiness Assessment described in Chapter 64 of the Alabama Medicaid Administrative Code, or does not complete the Readiness Assessment as required by Chapter 64 of the Alabama Medicaid Administrative Code.

(5) The Medicaid Agency may terminate a certificate based on an ICN’s failure to timely file required reports and updated information as required by Rules 560-X-64-.12(15) and 560-X-64-.08(8) or otherwise required by the Medicaid Agency after reasonable written notice with an opportunity to cure is provided by the Medicaid Agency.

(6) The Medicaid Agency may terminate a certificate based on material misrepresentations and/or omissions in applications and/or reports required of the ICN pursuant to Medicaid rules and any contract between the ICN and the Medicaid Agency.

(7) The Medicaid Agency may terminate a certificate for the failure on the part of the ICN to meet and/or maintain the solvency and other financial requirements set forth in Section 22-6-223 of the Alabama Code and rules promulgated by the Medicaid Agency.

(8) The Medicaid Agency may terminate a certificate should it reasonably determine that the continued operation of the ICN is hazardous to Medicaid beneficiaries or to the state after reasonable notice of the hazardous condition and an opportunity to cure is provided by the Medicaid Agency to the ICN.

(9) The Medicaid Agency may terminate an ICN's certificate for violations of state or federal law related to acts or omissions that could reasonably affect the delivery of care to Medicaid beneficiaries, committed by the ICN and/or any of its officers and directors.

(10) The Medicaid Agency may terminate an ICN's certificate if the ICN Program is terminated, suspended, or otherwise discontinued by the Medicaid Agency, State of Alabama, or as a result of action taken by CMS. The termination of a certificate under this subsection may not be appealed under subsection (11).

(11) Unless otherwise specified in this Rule, the ICN may request a fair hearing in writing if it is not satisfied with the termination action.

(12) A written request for a fair hearing must be received by the Medicaid Agency within thirty (30) calendar days from the date the notice of termination is mailed. The Medicaid Agency will not accept requests for fair hearings which are outside the thirty (30) calendar day limit.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq*; 42 CFR Part 438.
History: Emergency Rule filed and effective August 21, 2017. **Amended:** Filed August 21, 2017

Rule No. 560-X-64-.15 Grievances and Fair Hearings of Integrated Care Networks – NEW RULE

(1) An integrated care network (ICN) with a grievance concerning the Medicaid Agency as addressed in Section 22-6-225(c) of the Alabama Code, shall abide by the following procedures.

(2) For the purposes of this rule, an "ICN grievance" means any dispute or claim of an ICN against the Medicaid Agency for which an opportunity for hearing is provided by law or specific contractual provision, excepting disputes or claims for which the State of Alabama, the Medicaid Agency, or their officials, employees, or agents are immune under the constitutions or laws of the State of Alabama and/or the United States.

(3) An ICN shall request a fair hearing with the Medicaid Agency to review an ICN grievance. The request for fair hearing must be in writing and must be filed with the Medicaid Agency within sixty (60) calendar days from the date of the occurrence upon which the ICN grievance is based. Provided, however, this deadline shall not apply to any occurrence discovered upon receipt of an audit, reconciliation or report that provides notice to the ICN of an occurrence that was not

previously discoverable in the exercise of reasonable care. In such case the deadline for requesting a fair hearing shall be sixty (60) calendar days from the ICN's receipt of such audit, reconciliation, or report. An ICN's request for a fair hearing with the Medicaid Agency relating to the imposition of a sanction must be in writing and must be filed with the Medicaid Agency within thirty (30) calendar days of the date of the sanction notice. The written request shall include a statement of the factual and/or legal basis for the ICN's dispute or claim and a statement of the relief or action sought. The Medicaid Agency will not accept requests for fair hearings that are outside the filing deadline. The ICN may submit the written request for fair hearing to the Medicaid Agency by mail, hand-delivery, facsimile or electronic mail, and the request must be received by the Medicaid Agency on or before the filing deadline.

(4) Upon filing a written request for a fair hearing, the ICN may also request an informal conference with the Medicaid Agency to seek a resolution of the ICN grievance.

(5) If the ICN grievance is not resolved through informal conference with the Medicaid Agency, the ICN grievance shall be reviewed in a fair hearing before an impartial hearing officer in accordance with the requirements for contested case proceedings under the Alabama Administrative Procedure Act, Section 41-22-1 *et seq*. of the Alabama Code. The hearing authority for all fair hearings of ICN grievances shall be the Commissioner of the Medicaid Agency, who shall appoint one or more hearing officers to conduct fair hearings and submit findings and recommendations to the Commissioner for final decision on each ICN grievance. The hearing officer shall not have been involved in any way with the ICN grievance in question.

(6) A fair hearing shall be impartially conducted and held at the Medicaid Agency's central office in Montgomery. Written notice of the date, time, place and nature of the fair hearing shall be sent by certified mail to the ICN's address of record and may also be communicated by email or facsimile transmission by the Director, Hearings of the Medicaid Agency, or the designated hearing officer, at least ten (10) calendar days before the hearing is to be held. The notice shall comply with the requirements of Section 41-22-12(b) of the Alabama Code.

(7) The ICN may be represented at the fair hearing by legal counsel at its own expense. The ICN may call witnesses and may examine witnesses called by other parties.

(8) The Medicaid Agency shall be responsible for payment of the hearing officer(s) fees and expenses and any court reporter's fees and expenses related to the fair hearing.

(9) All fair hearings shall be conducted in accordance with the provisions of Sections 41-22-12 through 41-22-19 of the Alabama Code, unless otherwise noted in this rule. Within thirty (30) calendar days of the conclusion of the hearing, the findings and recommendations of the hearing officer shall be submitted to the Commissioner of the Medicaid Agency, who shall make a final decision within thirty (30) calendar days of the recommendation. The Medicaid Agency shall promptly send a copy of the final decision to the ICN's address of record by certified mail.

(10) The ICN may seek judicial review of the final decision of the Medicaid Agency in accordance with the provisions of Sections 41-22-20 and 41-22-21 of the Alabama Code.

(11) This rule shall not be applicable to any grievance or appeal of a provider or Medicaid Beneficiary filed pursuant to the provisions of Section 22-6-225(b) of the Alabama Code or rules promulgated by the Medicaid Agency pursuant thereto providing for grievances and appeals of providers and Medicaid Beneficiaries.

(12) Nothing in this rule is intended to create or establish new causes of action in any court. Nothing in this rule shall be construed as a waiver of any sovereign, qualified, or any other type of immunity.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-150 *et seq.* and 41-22-12 through 41-22-19.
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Rule No. 560-X-64-.16 Reserved – ICN Covered Population

Rule No. 560-X-64-.17 Reserved – ICN Covered Services

Rule No. 560-X-64-.18 Sanctions – NEW RULE

(1) Bases for Imposition of Sanctions on ICNs. The Medicaid Agency may impose sanctions on an integrated care network ("ICN") if the Medicaid Agency determines in its sole discretion that the ICN has violated any applicable federal or state law or regulation, the Alabama Medicaid State Plan, the risk contract between the Medicaid Agency and the ICN and the exhibits thereto (the "risk contract"), any policies, procedures, written interpretations, or other guidance of the Medicaid Agency, or for any other applicable reason described in 42 C.F.R. Part 438, Subpart I or the risk contract, including but not limited to a determination by the Medicaid Agency that an ICN acts or fails to act as follows:

(a) fails substantially to provide medically necessary services that the ICN is required to provide, under law or under its risk contract, to an enrollee covered under the risk contract;

(b) imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Alabama Medicaid program;

(c) acts to discriminate among enrollees on the basis of their health status or need for health care services (including termination of enrollment or refusal to reenroll a recipient, except as permitted under the Alabama Medicaid program, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services);

(d) misrepresents or falsifies information that it furnishes to the Medicaid Agency or to the Centers for Medicare and Medicaid Services (CMS);

(e) misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;

(f) distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved in writing by the Medicaid Agency or that contain false or materially misleading information;

(g) fails submit a corrective action plan that is acceptable to the Medicaid Agency within the time period specified by the Medicaid Agency's written notice or does not implement or complete the corrective action within the established time period;

(h) violates, as determined by the Medicaid Agency, any requirement of sections 1903(m) or 1932 of the Social Security Act or any implementing regulations; or

(i) violates, as determined by the Medicaid Agency, any requirement of Sections 22-6-220, *et seq.* of the Alabama Code or the rules promulgated thereunder.

(2) Types of Sanctions that May be Imposed on ICNs. The sanctions imposed by the Medicaid Agency against an ICN are as follows:

(a) requiring the ICN to develop and implement a corrective action plan that is acceptable to the Medicaid Agency;

(b) the intermediate sanctions described in 42 U.S.C. § 1396u-2(e)(2) and 42 C.F.R. Part 438, Subpart I, including but not limited to civil monetary penalties up to the maximum amounts set forth in 42 C.F.R. § 438.704;

(c) for acts or omissions which are not addressed by 42 C.F.R. Part 438, Subpart I, other provisions of this rule, or the risk contract and exhibits thereto, and which in the opinion of the Agency constitute willful, gross, or fraudulent misconduct, the assessment of a monetary penalty amount up to $100,000 per act or omission;

(d) denial of payments under the risk contract for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with 42 C.F.R. § 438.730(e);

(e) the sanctions set forth in the risk contract and exhibits thereto;

(f) any other sanction available under federal or state law or regulation, including without limitation Rule No. 560-X-37-.01;

(g) any other sanction reasonably designed to remedy noncompliance and/or compel future compliance with the risk contract or federal or state law or regulation, pursuant to the Medicaid Agency's authority under 42 C.F.R. § 438.702(b); and

(h) termination of the risk contract, in accordance with the terms of the risk contract.

(3) Sanctions that May be Imposed on Probationary ICNs. If the Medicaid Agency in its sole discretion determines that an organization with probationary ICN certification has acted or failed to act in a manner that is sanctionable against an ICN in accordance with this rule, the Medicaid Agency may (a) impose any applicable sanction described in section 2 of this rule against such probationary ICN, and/or (b) exercise any other applicable authority that the Agency may exercise under other rules of the Medicaid Agency or other applicable state and federal laws and regulations, including but not limited to denial of the probationary ICN's application for full certification. Without limiting the foregoing, the Medicaid Agency may impose sanctions against a probationary ICN in the form of civil monetary penalties, up to the maximum amounts set forth in 42 C.F.R § 438.704, if it determines that a probationary ICN:

(a) acts to discriminate among enrollees or potential enrollees on the basis of their health status or need for health care services;

(b) misrepresents or falsifies information that it furnishes to CMS or the Medicaid Agency; or

(c) misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

(d) violates any requirement of Sections 22-6-220, *et seq.* of the Alabama Code or the rules promulgated thereunder; or

(e) violates any other federal or state law or regulation, the Alabama Medicaid State Plan, or any policies, procedures, written interpretations, or other guidance of the Medicaid Agency.

(4) Notice of Sanction. Before the Medicaid Agency imposes a sanction under this rule, it will give the affected organization timely written notice explaining (a) the basis and nature of the sanction, (b) if applicable, the organization's right to request a fair hearing under Rule No. 560-X-64-.15, and (c) any other due process protections pursuant to the risk contract or that the Medicaid Agency elects to provide.

(5) Waiver of Fair Hearing and Reduction of Sanction. Except as otherwise required by applicable law, in the event of an imposed sanction in the form of a civil monetary penalty according to this rule and/or the risk contract and exhibits thereto, the amount of the sanction imposed will be reduced by thirty five percent (35%) if the ICN waives, in writing, its right to a fair hearing within thirty (30) calendar days from the date of notice imposing the sanction. The reduction under this section only applies to sanctions that could be appealed under Rule No. 560-X-64-.15 and not to any other outstanding sanctions imposed on the ICN by the Medicaid Agency.

(6) Pre-termination Hearing. Before terminating a risk contract under 42 C.F.R. § 438.708, the Medicaid Agency will provide the ICN with a pre-termination hearing to be conducted in accordance with the procedures for fair hearings set forth in Rule No. 560-X-64-.15. Prior to such pre-termination hearing, the Medicaid Agency will, in accordance with 42 C.F.R. § 438.710:

(a) give the ICN written notice of the Medicaid Agency's intent to terminate the risk contract, the reason or reasons for termination of the risk contract, and the time and place of the hearing;

(b) after the hearing, give the ICN written notice of the decision affirming or reversing the proposed termination of the risk contract and, for an affirming decision, the effective date of termination; and

(c) For a decision affirming the determination to terminate the risk contract, give enrollees of the ICN notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

(7) Temporary Management. Notwithstanding anything herein or in the risk contract to the contrary, if the Medicaid Agency determines that an ICN has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or in 42 C.F.R. Part 438, Subpart I, the imposition of temporary management in accordance with 42 C.F.R. § 438.706(b) and the risk contract shall not be delayed by an administrative review or hearing. The Agency may remove temporary management if, and only if, it determines that the ICN can ensure that the sanctioned behavior shall not recur.

(8) Sanctions Not Exclusive. The imposition of a single sanction by the Medicaid Agency does not preclude the imposition of any other sanction or combination of sanctions or any remedy authorized under the risk contract for the same deficiency. The Medicaid Agency may impose sanctions under this rule in addition to or in lieu of exercising any other right, remedy, or authority that the Medicaid Agency may exercise under other rules promulgated by the Medicaid Agency, other applicable state and federal laws and regulations, or any contract between the Medicaid Agency and an ICN or probationary ICN. Nothing in this rule shall restrict or prevent the Medicaid Agency or the State of Alabama from obtaining declaratory, injunctive or equitable relief, or from recovering damages from an ICN, probationary ICN, and/or any other person or entity for breach of contract or any other cause of action.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
Statutory Authority: Code of Alabama, 1975 Section 22-6-220 *et seq*; 42 CFR Part 438.
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Rule No. 560-X-64-.19 Reserved – Readiness Assessment Requirements