

Chapter 62. Regional Care Organizations - REPEALED

Rule No. 560-X-62-.01 Certificate in Order to Collaborate with other Entities, Individuals, or Regional Care Organizations

(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 22-6-163 of the Alabama Code. A Collaborator is defined in Section 22-6-150(4) 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 regional care organizations 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) 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, 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 a RCO, to enroll as a provider with a RCO, or to engage in other activity.

(f) Identification of the Medicaid region(s) in which the applicant intends to help establish or develop a RCO, to enroll as a provider with a RCO, or to engage in other activity.

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

(h) 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 to Medicaid beneficiaries;

(ii) result in cost containment in providing health care services;

(iii) result in enhancements in technology; and

(iv) maintain competition in the health care services market.

(i) 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, (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 health care 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 RCO or 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 22-6-163 of the Alabama Code shall be issued to allow collective negotiations, bargaining, and cooperation among Collaborators and RCOs in accordance with Sections 22-6-150, *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, 2017. 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, and cooperation among Collaborators and RCOs in accordance with Sections 22-6-150, *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 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 22-6-163(c) of the Alabama Code and subsection 2(i) 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 22-6-163(c) of the Alabama Code and subsection 2(i) 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 a RCO 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 RCOs to facilitate the development and establishments of the RCOs and 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 22-6-150 *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 22-6-150 *et seq.*

History: Emergency Rule filed and effective October 11, 2013. **Amended:** Filed December 17, 2013; effective January 21, 2014. **Amended:** Filed August 11, 2016; effective September 26, 2016. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.02 Active Supervision Of Collaborations

(1) The Medicaid Agency shall actively monitor and supervise the collective negotiations, bargaining, and cooperation among Collaborators that have been issued Certificates to Collaborate by the Medicaid Agency and Regional Care Organizations (RCOs) in accordance with Sections 22-6-150, *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 March 1 and September 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 22-6-163 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 a RCO or enrolling as a provider with a RCO;

(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 a RCO must include additional information concerning whether the RCO is expected to:

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

(b) result in cost-containment in providing health care services;

(c) result in enhancements in technology;

(d) maintain competition in the health 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.

(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 22-6-163 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 Alabama Administrative Code r. 560-X-62-.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: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed December 17, 2013; effective January 21, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.03 Governing Board of Directors

(1) A regional care organization and an organization with probationary regional care organization certification shall have a governing board of directors composed of the following members:

(a) Twelve members shall be persons representing risk-bearing participants in the regional care organization or organization with probationary certification. A participant bears risk by contributing cash, capital, or other assets to the regional care organization. A participant also bears risk by contracting with the regional care organization to treat Medicaid beneficiaries at a capitated rate per beneficiary or to treat Medicaid beneficiaries even if the regional care organization does not reimburse the participant. To be a risk-bearing board member, the capitated contract and/or contribution of cash, capital or other assets contributed by the risk-bearing participant must be meaningful as determined in the sole discretion of the Medicaid Agency.

(b) Eight members shall be persons who do not represent a risk-bearing participant in the regional care organization.

(i) Five members shall be medical professionals who provide care to Medicaid beneficiaries in the region.

Three of these members shall be primary care physicians, one an optometrist, and one a pharmacist. One primary care physician shall be from a Federally Qualified Health Center appointed jointly by the Alabama Primary Health Care Association and the Alabama Chapter of the National Medical Association and the other two primary care physicians shall be appointed by the Medical Association of the State of Alabama, or its successor organization. The optometrist shall be appointed by the Alabama Optometric Association, or its successor organization. The pharmacist shall be appointed by the Alabama Pharmacy Association, or its successor organization. All five medical professionals shall work in the region served by the regional care organization. None of these members shall be a risk-bearing participant in the regional care organization or be an employee of a risk-bearing participant, but these members may contract with the regional care organization on a fee-for-service basis.

(ii) Three of the eight members shall be community representatives and may not be risk-bearing participants in the regional care organization or employees of a risk-bearing participant. They are comprised as follows:

(A) The chair of the citizen's advisory committee established pursuant to the Medicaid Administrative Code.

(B) A citizen's advisory committee member, elected by the committee, who is a representative of an organization that is part of the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations.

(C) A business executive, nominated by a chamber of commerce in the region, who works in the region.

(2) At the time of full certification, six of the twelve risk-bearing participants required on the governing board of directors, pursuant to Section (1)(a) hereof and Section 22-6-151(c)(1)(a) of the Alabama Code, shall be “primary medical providers,” “core specialists” and/or “facilities” as defined in Rule No. 560-X-62-.12(1)(a)-(c), or representatives thereof, who treat Medicaid beneficiaries in the region served by the organization.

(3) A majority of the members of the board may not represent a single provider; however, this shall not apply to a regional care organization if only one entity offers to be a risk-bearing participant as defined in Section 22-6-151(c)(1)(a) of the Alabama Code. 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.

(4) 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 probationary regional care organization certification or full regional care organization certification without approval.

(5) Any vacancy on the governing board of directors in connection with members appointed as described in Section 22-6-151(c)(1)(b) or Section 22-6-151(c)(1)(c) shall be filled by the appropriate authority as designated in that subsection. A vacancy in a board of directors' seat held by a representative of a risk-bearing participant as defined in Section 22-6-151(c)(1)(a) shall be filled by the regional care organization. The Medicaid Commissioner shall appoint a replacement board member if a board seat is left vacant for at least three months.

(6) 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, unless the legal entity operates a hospital, in which case such legal entity shall be considered a hospital provider type. The governing board shall set policy and direction for the regional care organization 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 physicians appointed to the board by the Medical Association of the State of Alabama pursuant to Section 22-6-151(c)(1)(b).

(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 Medicaid region. All non-risk bearing members of the governing board must reside in the region during his or her tenure as a board member.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed July 18, 2014; effective August 21, 2014. **Amended:** Filed November 12, 2014; effective December 17, 2014. **Amended:** Filed March 11, 2016; effective April 26, 2016. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.04 Citizens' Advisory Committee

A citizens' advisory committee shall advise the organization on ways the organization may be more efficient in providing quality care to Medicaid beneficiaries. In addition, an advisory committee shall carry out other functions and duties assigned to it by a regional care organization and approved by the Medicaid Agency. Each regional care organization shall have a citizens' advisory committee, as shall an organization seeking to become a regional care organization, which membership shall be inclusive and reflect the racial, gender, geographic, urban/rural, and economic diversity of the state. The committee shall meet all of the following criteria:

- (1) Be selected in a method established by the organization seeking to become a regional care organization, or established by the regional care organization, and approved by the Medicaid Agency.
- (2) At least 20 percent of its members shall be Medicaid beneficiaries or, if the organization has been certified as a regional care organization, at least 20 percent of its members shall be Medicaid beneficiaries enrolled in the regional care organization. It shall be applicant'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.
- (3) Include members who are representatives of organizations that are part of the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations.
- (4) Include only persons who live in the Medicaid region the organization plans to serve; or if the organization has become a regional care organization, include only persons who live in the Medicaid region served by the regional care organization. The membership of the committee shall be inclusive and reflect the racial, gender, geographic, urban/rural, and economic diversity of the region.
- (5) Elect a chair.
- (6) Meet at least every three months.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed March 28, 2014; effective May 2, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.05 Probationary Certification of Organizations Seeking to Become Regional Care Organizations

(1) An organization may receive probationary certification as a regional care organization (Probationary Certification) upon submission of an application to the Medicaid Agency that satisfies the requirements of the Medicaid Administrative Code and Sections 22-6-150, *et seq.* of the Alabama Code.

(2) An organization seeking Probationary Certification shall be incorporated as a nonprofit corporation under Alabama law. The Certificate of Formation of the organization shall mandate 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) all 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 shall have a governing board of directors acceptable to the Medicaid Agency for each Medicaid region the organization plans to serve that meets the requirements of Section 22-6-151(c) of the Alabama Code and the Medicaid Administrative Code.

(4) The Medicaid Agency shall have the 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 regional care organization certification without approval.

(5) An organization seeking Probationary Certification shall have a citizen's advisory committee for each Medicaid region the organization plans to serve that meets the requirements of Section 22-6-151(d) of the Alabama Code and the Medicaid Administrative Code.

(6) All applications for Probationary Certification to be effective October 1, 2014 must be submitted to the Medicaid Agency between May 12 and August 1, 2014. Pursuant to Section 22-6-156 (2), the Medicaid Agency may accept applications for Probationary Certification to be effective January 1, 2015 that are submitted between August 2, 2014 and September 30, 2014. The Medicaid Agency shall have the power, at its sole discretion, to permit an applicant to supplement its application to the Medicaid Agency.

(7) 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, email 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, medical director and/or administrator of the organization and any other persons responsible for the healthcare 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 each Medicaid region the organization plans to serve;

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

(h) Copies of any organizational and governing 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 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.

(8) All applications for Probationary Certification shall also include the following information concerning its governing Board of Directors for each Medicaid region the organization plans to serve 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;

(c) 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 Medicaid region;

(d) With respect to each Board of Directors member, identification whether each individual:

(i) is himself/herself a risk bearing participant or that he/she represents a risk bearing participant in the organization as described in Section 22–6–151(c)(1) of the Alabama Code, and the nature of his/her participation as a risk bearing participant;

(ii) is a medical professional who provides care to Medicaid beneficiaries in the region and, if so, whether such individual is a primary care physician, an optometrist, or a pharmacist. The organization shall certify that the medical professionals are appointed by the associations or organizations identified in Section 22–6–151 (c)(1)(b) of the Alabama Code and meet the other requirements set forth in that provision;

(iii) is a community representative qualified, elected or appointed consistent with Section 22 – 6 – 151 (c)(1)(c) of the Alabama Code.

(e) With respect to each Board of Directors Member, background information pertaining to any adverse action against any occupational, professional or vocational license or permit; criminal offences other than civil traffic offences; civil judgments involving dishonesty, breach of trust, or foreclosure; and any bankruptcy proceeding.

(f) Certification that a majority of the Board of Directors members do not and will not represent a single provider. Alternatively, certification that only one entity has offered to be a risk-bearing participant in the organization as defined in Section 22-6-151(c)(1) of the Alabama Code.

(9) All applications for Probationary Certification shall also include the following information concerning its citizen’s advisory committee for each Medicaid region the organization plans to serve for the Medicaid Agency’s review and approval:

(a) The name, occupation, mailing address, email address, and telephone number of each member of the citizen’s advisory committee;

(b) Information evidencing that the membership of the citizen’s advisory committee is inclusive and reflects the racial, gender, geographic, urban/rural and economic diversity of the region and the members of its citizen’s advisory committee;

(c) A description of the method the organization used to select the members of its citizen’s advisory committee;

(d) Identification of the members of the citizen’s advisory committee who are Medicaid beneficiaries who reside in the Medicaid region the organization plans to serve. It shall be applicant’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;

(e) Identification of the members of the citizen's advisory committee who are representatives of organizations that are part of the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations.

(10) An organization applying for Probationary Certification shall be organized in a manner consistent with the accomplishment of its stated mission which shall include, as a minimum, delivery of basic health care services in accordance with Section 22-6-150, *et seq.* of the Alabama Code.

(11) 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 of health care services delivery, quality improvement and utilization review programs including biannual meetings at a minimum for the purpose of evaluation and improvement of the health services of the organization and to respond to recommendations and findings of the quality improvement 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 health services. All records must be maintained for not less than five (5) years;

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

(12) 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 in the creation of the organization has been and will continue to be in good faith, (b) that such bargaining 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 to citizens who are Medicaid eligible at the lowest possible cost, (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 services to Medicaid beneficiaries in all counties of each Medicaid region the organization plans to serve.

(13) 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.

(14) 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 regional care organization 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 medical service delivery network, potential funding sources, organizational issues and other topics may be discussed.

(15) The Medicaid Agency shall review the application and any additional documentation and information and, if the Medicaid Agency in its discretion determines that the applicant meets the requirements for probationary certification, the Medicaid Agency shall issue the organization a Probationary Certificate as a Regional Care Organization.

(16) A Probationary Certificate as a Regional Care Organization shall be effective immediately upon issuance by the Medicaid Agency and shall expire no later than the date specified in Section 22-6-159(a)(2). The issuance of a Probationary Certificate as a Regional Care Organization provides no presumption that an organization shall be certified as a Regional Care Organization.

(17) The holder of a Probationary Certificate as a Regional Care Organization (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 suspend or revoke a Probationary Certification upon a finding that the organization no longer meets the requirements for Probationary Certification.

(18) All applications submitted pursuant to this rule, all Probationary Certificates as a Regional Care Organization, and the names and addresses of all organizations and contact persons to whom the Medicaid Agency issues Probationary Certificates as a Regional Care Organization shall be public records and shall be subject to disclosure. The Medicaid Agency may redact confidential or personal information prior to disclosure.

(19) Any person or entity may notify the Medicaid Agency of conduct of a Certificate Holder or a Board of Directors member 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 a Regional Care Organization 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.

(20) Whenever an application for probationary certification as a regional care organization is denied or a Probationary Certificate as a Regional Care Organization is revoked, 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: Sharon Weaver, Administrator, Administrative Procedures Office.

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Rule No. 560-X-62-.06 Active Supervision of Organizations with Probationary Certification

(1) The Medicaid Agency shall actively monitor and supervise the collective negotiations, bargaining, and cooperation among Collaborators as defined in Section 22-6-150(4) of the Alabama Code and each organization that receives probationary certification as a regional care organization (“Probationary Organization”) in accordance with Sections 22-6-150, *et seq.* of the Alabama Code. Each Probationary Organization shall submit an on-line 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 22-6-163 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, or cooperation during the reporting period;

(b) A description of progress the Probationary Organization has made during the reporting period establishing or developing a regional care organization (RCO) that may gain full RCO certification on or before October 1, 2016;

(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) All periodic reports submitted by 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 RCO is expected to:

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

(b) result in cost-containment in providing health care 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 Section 22-6-150, *et seq.* of the Alabama Code.

(4) The Probationary Organization 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 22-6-163 of the Alabama Code.

(5) Each Probationary Organization must also submit the following reports to the Medicaid Agency:

(a) On or before February 1, 2015, a report demonstrating to the Medicaid Agency's approval the ability to establish an adequate medical service delivery network not later than April 1, 2015;

(b) On or before July 1, 2015, a report demonstrating to the Medicaid Agency's approval the ability to meet the solvency and financial requirements for a regional care organization pursuant to Section 22-6-151(e)(1) of the Alabama Code and Medicaid Administrative Code not later than October 1, 2015; and

(c) On or before May 1, 2016, a report demonstrating to the Medicaid Agency's approval that the organization is capable of providing services pursuant to a risk contract not later than October 1, 2016.

The Medicaid Agency shall issue future regulations defining each of the requirements referenced in this subsection.

(6) 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 Rule 560-X-62-02.

(7) 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.

(8) 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.

(9) 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 a Regional Care Organization 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: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed March 28, 2014; effective May 2, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.07 Contract for Case-Management Services with Organization with Probationary Certification

(1) The Medicaid Agency may contract for specific case-management services with an organization that the Medicaid Agency has granted probationary regional care organization certification on such terms and conditions required by the Medicaid Agency.

(2) Probationary certified regional care organizations desiring to contract for specific case management services with the Medicaid Agency must submit a Response to a Medicaid Request for Proposal. The Request for Proposal and/or Contract shall set forth terms and conditions required by the Medicaid Agency to perform case management services. Requests for Proposals and/or Contracts for specific case-management services in each Medicaid region shall be issued and available for inspection on the Medicaid Agency's website. Requests for

Proposals and/or Contracts shall set forth the scope of work, pricing, general information, entity qualifications and references, submission requirements, evaluation and selection process, any requirements for establishing an adequate medical service delivery network, any solvency and financial requirements, general terms and conditions, and other provisions for case-management services. Any organization that the Medicaid Agency has granted probationary regional care organization certification by October 1, 2014 shall be eligible to submit a proposal to provide case-management services in the Medicaid region(s) for which it has received probationary certification. The Medicaid Agency may, in its discretion, allow one or more organizations granted probationary regional care organization certification after October 1, 2014 to submit proposals to provide case-management services. The Medicaid Agency may contract for specific case-management services with one or more organizations with probationary certification.

(3) Pursuant to Section 22-6-162 of the Alabama Code, if any organization that has contracted with the Medicaid Agency for case-management services has failed to gain full regional care organization certification or has had its probationary certification terminated or revoked, then the contract for case-management services shall be terminated and that organization shall refund half the payments, made by the Medicaid Agency to the organization for case-management services, paid over the previous 12 months.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed March 28, 2014; effective May 2, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.08 Conflict of Interest Policy for Directors and Officers of Regional Care Organizations

(1) A regional care organization (RCO) and an organization with probationary RCO 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 RCO or organization with probationary RCO 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 within the preceding two years 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 RCO or organization with probationary RCO 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. Each director and officer shall file

such disclosure statement with the RCO'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;
 - (b) Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise; and
 - (c) Address remedial action for directors or officers that fail to comply with the policy.
- (3) A RCO and an organization with probationary RCO 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 RCO entering into a contract with the Medicaid Agency.
- (4) All employees and agents of the Medicaid Agency who have responsibilities relating to contracts with a RCO or an organization with probationary RCO 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) The Medicaid Agency may require a RCO or an organization with probationary RCO 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: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed July 18, 2014; effective August 21, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.09 Provider Standards Committee

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

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

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

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

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

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

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

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

- (5) At least 60 percent of the members of the provider standards committee shall be physicians licensed in the State of Alabama who provide care to Medicaid beneficiaries served by the regional care organization. The medical practices of the physician members shall be consistent with and reflective of the medical services provided Medicaid beneficiaries in the Medicaid region.
- (6) The provider standards committee shall also include at least three providers who are not physicians and who provide care or services to Medicaid beneficiaries served by the regional care organization.
- (7) The regional care organization medical director shall serve as chairperson of the provider standards committee.
- (8) No more than 50 percent of the members of the provider standards committee shall reside in one county of the Medicaid region.
- (9) The members of the provider standards committee shall serve two-year terms.
- (10) The provider standards committee shall meet at least semi-annually and at other times upon the written request of the chairperson or a majority of the members. Written notice indicating the date, time and place of each meeting shall be sent to each member of the provider standards committee not less than 7 calendar days prior to said meeting by the chairperson or any member of the committee; provided, however, that any member of the committee may waive his or her right to such notice and such waiver may be oral, by telephone, or by any such means of communication.
- (11) The members of the provider standards committee may participate in a meeting of the committee by means of telephone conference, videoconference, or similar communications equipment by means of which all persons participating in the meeting may hear each other at the same time. Participation by such means shall constitute presence in person at a meeting for all purposes, including the establishment of a quorum.
- (12) The Medicaid Agency may adopt and implement performance standards, quality measures and quality matrices in addition to or in conflict with the performance standards and quality measures adopted by a provider standards committee. In the event of any conflict between a performance standard, quality measure or quality matrix adopted by a provider standards committee and a performance standard, quality measure or quality matrix adopted by the Medicaid Agency, the performance standard, quality measure or quality matrix adopted by the Medicaid Agency shall supersede the performance standard, quality measure or quality matrix adopted by the provider standards committee.
- (13) The Medicaid Agency shall decide any disagreement concerning whether a specific issue, dispute or matter is to be considered by a provider standards committee under this rule or a contract dispute committee under Rule No. 560-X-62-.11.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed July 18, 2014; effective August 21, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.10 Minimum Fee-For-Service Reimbursement Rates

(1) In accordance with Section 22–6–153 (c) of the Alabama Code, the minimum fee-for-service reimbursement rates that a regional care organization shall pay providers for applicable Medicaid services provided to a Medicaid beneficiary shall be the prevailing Medicaid fee-for-service payment schedule, unless otherwise jointly agreed to by a provider and a regional care organization through a contract or mandated by federal law.

(2) The minimum provider reimbursements shall be incorporated into the actuarially sound rate development methodology for each regional care organization. The Medicaid Agency shall submit the methodology and resulting rates to the Centers for Medicare and Medicaid Services for approval.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-153 (c).

History: New Rule: Filed July 18, 2014; effective August 21, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.11 Provider Contract Disputes

(1) All provider contracts of an organization granted probationary or final certification as a regional care organization shall be subject to review and/or approval of the Medicaid Agency.

(2) Any Medicaid provider who is dissatisfied with any term or provision of the agreement or contract offered by or with a regional care organization shall first seek redress by filing a grievance with the regional care organization. The Medicaid provider may contest any terms or provisions of the agreement or contract offered by or with the regional care organization other than (a) terms or provisions required by the Medicaid Agency or the Centers for Medicare and Medicaid Services and (b) terms or provisions identifying performance standards or quality measures subject to review by a provider standards committee under Rule No. 560-X-62-.09. The contractual application of the provider standards committee standards and measures shall be subject to review but not the performance standards or quality measures themselves.

(3) In providing redress, the regional care organization shall afford the Medicaid provider within 5 business days of the filing of the grievance, a review and final decision by a panel composed of the following:

- (a) A representative of the regional care organization.
- (b) The same type of provider.

(c) A representative of the citizen's advisory board appointed by the chairperson of the citizen's advisory board.

(4) After seeking redress with the regional care organization, a Medicaid provider or the regional care organization who remains dissatisfied may request a review of such disputed term or provision by the Medicaid Agency.

(a) The party requesting review shall submit the request for review both to the Medicaid Agency and the other party by overnight delivery, facsimile or electronic mail within 7 business days of the decision of the panel.

(b) Within 5 business days of the request for review, the regional care organization shall submit both to the Medicaid Agency and the Medicaid provider by overnight delivery, facsimile or electronic mail copies of the panel's decision and all documents and materials provided to or considered by the panel in reaching its decision.

(c) Upon receipt of the request for review, the Medicaid Agency may request any information and documents to review the disputed term or provision and the regional care organization and the Medicaid provider shall have 7 business days to provide the Medicaid Agency with the requested information and documents and any additional supporting information and documents that the regional care organization or Medicaid provider wishes to present to the Medicaid Agency.

(d) The Medicaid Agency shall have 7 business days after the receipt of any requested information to issue, in writing, its decision regarding the dispute which shall be binding on the regional care organization and the Medicaid provider.

(e) The failure of either party to provide requested information or documents shall not delay or prevent the Medicaid Agency from issuing its decision.

(5) Within 30 calendar days of receipt of the Medicaid Agency's decision, the Medicaid provider or the regional care organization may request a review of the Medicaid Agency's decision by a contract dispute committee.

(6) At any time before the scheduled hearing before the contract dispute committee, an informal disposition of the dispute may be made by stipulation, agreed settlement or by another method agreed upon by the parties in writing.

(7) The contract dispute committee shall be appointed by the Medicaid Agency and shall be composed of the following:

(a) Two Medicaid providers from other Medicaid regions. The two Medicaid providers shall be selected by the affected provider's professional or business association. If the provider is not a member of a professional or business association, the professional or business association for which the provider is eligible for membership shall appoint the providers.

(b) Two representatives of regional care organizations from other Medicaid regions. The two representatives of the regional care organizations shall be appointed by the Medicaid

Agency from a list of four representatives selected by regional care organizations from the unaffected Medicaid regions. Prior to the beginning of each calendar year, the regional care organization(s) in each Medicaid region shall provide the Medicaid Agency the name and contact information of at least one representative from that Medicaid region who the Medicaid Agency may appoint to the contract dispute committee to consider specific disputes. The regional care organization(s) in the Medicaid region shall promptly designate a replacement representative from that Medicaid Region when a vacancy exists.

(c) An administrative law judge selected by the Medicaid Agency who shall preside over the hearing.

(8) All hearings and meetings of the contract dispute committee shall be conducted at the Medicaid Agency's central office in Montgomery.

(9) All hearings of the contract dispute committee shall be fair and impartial. The order in which evidence is to be presented shall rest within the sound discretion of the contract dispute committee. All oral testimony shall be given under oath or affirmation. Each party or its representative will be allowed to testify, and each party may call additional witnesses to testify during the hearing. Hearings shall be confined to evidence relevant and material to the disputed terms and conditions. Subject to the discretion of the contract dispute committee, witnesses may be excluded from the hearing until called to testify. Those testifying shall be subject to direct and cross-examination by the parties or their representatives and the committee. Documentary evidence may be received in the form of copies of original documents. The parties may, subject to the approval of the contract dispute committee, enter into stipulations as to all or a portion of the facts involved in a proceeding. The contract dispute committee may make a decision on the basis of such stipulations or may set the matter down for hearing and take such further testimony and receive such further evidence as deemed necessary. The contract dispute committee may, but is not required to, follow the procedures or requirements of the Administrative Procedure Act, the Alabama Rules of Civil Procedure or the Alabama Rules of Evidence in conducting hearings or reaching decisions.

(10) All hearings of the contract dispute committee shall be recorded by the Medicaid Agency either by mechanized means or by a qualified shorthand reporter but need not be transcribed unless an appeal is taken and a request for transcription of the hearing is made by a party.

(11) The standard of review for the contract dispute committee shall be one of fairness and reasonableness. The contract dispute committee shall undertake a de novo review of the dispute and shall consider the following:

(a) Current and historic reimbursement rates.

(b) Prevailing terms and standards in contracts currently in existence.

(c) Customs, policies, and procedures prevalent in other Medicaid regions and under the Alabama Medicaid Program.

(d) Other matters the committee may deem relevant to its decision.

(12) The contract dispute committee shall issue a written ruling on such disputed term or provision stating its findings of fact and conclusions of law no more than 20 calendar days after the dispute is submitted to it. The contract dispute committee's decision shall be binding on the regional care organization and the Medicaid provider.

(13) The regional care organization and the Medicaid provider shall each reimburse the Medicaid Agency for one-half of the following expenses:

(a) The administrative law judge's fees and expenses incurred in serving on the contract dispute committee.

(b) Any court reporter's fees and expenses incurred in reporting or transcribing the proceedings of the contract dispute committee.

(14) If the Medicaid provider or the regional care organization is dissatisfied with the decision of the contract dispute committee, the Medicaid provider or regional care organization shall file an appeal in the Montgomery County Circuit Court within 30 calendar days of such decision.

(15) The Medicaid Agency shall decide any disagreement that may arise concerning whether a specific issue, dispute or matter is to be considered by a contract dispute committee under this rule or a provider standards committee under Rule No. 560-X-62-.09.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed July 18, 2014; effective August 21, 2014. **Repealed:** Filed January 22, 2019.

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

(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) Pediatrician
- (vi) Obstetrician or Gynecologist
- (vii) Rural Health Clinic

(b) *Core Specialist* is defined as each of the following:

- (i) Allergist (for the purposes of this rule, an ENT or an Otolaryngologist will qualify as this specialist)
- (ii) Anesthesiologist
- (iii) Cardiologist

- (iv) Cardiovascular Surgeon
- (v) Dermatologist
- (vi) Gastroenterologist
- (vii) General Surgeon
- (viii) Neurologist
- (ix) Oncologist
- (x) Ophthalmologist
- (xi) Optometrist
- (xii) Orthopedic surgeon
- (xiii) Psychiatrist
- (xiv) Pulmonologist
- (xv) Radiologist
- (xvi) Urologist

(c) *Facility* is defined as each of the following:

- (i) Hospitals as defined in Rule 560-X-7-.02
- (ii) Inpatient Psychiatric Hospitals/Units
- (iii) Laboratory Services
- (iv) End Stage Renal Disease Treatment and Transplant Center
- (v) Outpatient Mental Health Center
- (vi) Independent Radiology Center

(d) *Non-Core Specialist* is defined as any medical provider type not listed above which is needed to appropriately service the regional care organization/alternate care provider (“RCO/ACP”) members and provide care delivery for all of the services and benefits covered by the RCO/ACP program.

(e) *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 to enrollees of the RCO/ACP.

(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 RCO/ACP. The following factors shall be considered in determining an appropriate provider network.

(A) The anticipated Medicaid enrollment in its service area 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 RCO/ACP;

(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;

(F) For rating periods for contracts with an RCO/ACP beginning on or after

July 1, 2018:

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

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

(3) 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;

(4) 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;

(5) 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).

(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	
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
Office Wait Times	
Walk-Ins	2 hours or schedule an appointment within the standards of appointment availability
Scheduled Appointment	1 hour
Life-Threatening Emergency	Immediate

(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) Must have an adequate amount of Non-Core Specialists as needed to appropriately service its members and provide care delivery for all of the services and benefits covered by the RCO/ACP program. These specialties are not required to be geographically located within the RCO’s region.

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

Provider Type	Minimum Number	Distance
PMPs excluding Pediatricians and Delivering Healthcare Providers	1.5 per 1,000 enrollees, with a minimum of two	50 miles from each enrollee’s residence
Core Specialists (for each of the types identified in section (1)(b) of this rule)	0.2 per 1,000 enrollees	50 miles from each enrollee’s residence
Pediatricians	1.5 per 1,000 enrollees under the age of 21, with a minimum of two	50 miles from each enrollee’s residence
Obstetricians and Gynecologists	No requirement	50 miles from each enrollee’s residence
Facilities (for each of the types identified in section (1)(c) of this rule)	No requirement	50 miles from each enrollee’s residence

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

(ix) Maintains a network to serve the region’s newborn population in the following areas:

(A) Delivering obstetricians, gynecologists, or other physicians that have credentials to perform deliveries must have admitting privileges to a delivery hospital in the RCO/ACP’s network.

(B) The RCO/ACP has access to an appropriate level neonatal intensive care unit (NICU). The NICU must be able to provide the appropriate level of medically necessary care for high-risk newborns. In regards to distance, the NICU must be at least one of the following:

- (1) the closest NICU to the delivering hospital;
- (2) the closest NICU to the newborn’s mother’s residence; or
- (3) the next closest NICU of either (1) or (2) above.

(x) The RCO/ACP must establish agreements with the Alabama Department of Mental Health (ADMH) to ensure that each RCO/ACP establishes and maintains an adequate network of ADMH certified behavioral health providers to appropriately address the needs of beneficiaries in the demonstration populations who have mental illnesses and

substance abuse disorders. The RCO/ACP provider network must include ADMH-certified mental health and substance abuse providers.

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

(xii) Requires out-of-network providers to coordinate with the RCO/ACP 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.

(xiii) For rating periods for contracts with an RCO/ACP beginning on or after July 1, 2018, provides sufficient family planning providers to ensure timely access to covered services.

(2) Each entity with probationary regional care certification must demonstrate to the satisfaction of the Medicaid Agency that its Service Delivery Network meets the requirements of this rule. 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) On or before February 1, 2015, each entity with probationary regional care organization certification must submit a status report to the Medicaid Agency demonstrating how it intends to establish an adequate medical service delivery network by April 1, 2015.

(b) Not later than April 1, 2015, each entity with probationary regional care organization certification must demonstrate to the Medicaid Agency's preliminary approval the ability, as evidenced by appropriate assurances and supporting documents, to establish a Service Delivery Network that meets the requirements of this rule.

(c) On or before February 28, 2017, or such later date as may be determined by the Medicaid Agency, each entity with probationary regional care organization certification, RCO, and ACP must demonstrate to the Medicaid Agency's approval the existence of an adequate Service Delivery Network that meets the requirements of this rule as demonstrated in part by executed provider contracts and/or Medicaid approved exceptions and as further demonstrated to the satisfaction of the Medicaid Agency which shall, except as otherwise provided herein, meet ninety percent (90%) of the Provider-Specific Network Criteria of section (e)(viii) above. The Agency, in its sole discretion, may grant the RCO/ACP an exception of any Provider-Specific Network Criteria.

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

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

(B) The exception the RCO/ACP is requesting;

(C) Steps taken by the RCO/ACP to comply with requirement before requesting the exception;

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

(E) Description of the RCO/ACP's plan to adequately provide covered services if exception is granted.

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

(iii) If the Agency grants an exception, the RCO/ACP must submit quarterly reports to the Agency detailing enrollee access to the provider type subject to the exception.

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

(v) 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.

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

(3) Notwithstanding the minimum network requirements of this rule, Medicaid enrollees shall have the option to be treated at the nearest hospital, NICU, 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 entity 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 probationary regional care organization, final regional care organization or alternate care provider shall be governed by federal access standards which may be found in their entirety in 42 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 22-6-150 *et seq*; 42 C.F.R. § 438.68; 42 C.F.R. §§ 438.206 - 438.210.

History: New Rule: Filed July 18, 2014; effective August 21, 2014. **Amended:** Filed December 3, 2014; effective January 7, 2015. Emergency Rule filed and effective March 22, 2016. **Amended:** Filed June 10, 2016; effective: July 25, 2016. **Amended:** Filed December 16, 2016; effective January 30, 2017. **Amended:** Emergency Rule filed and effective February 24, 2017. **Amended:** Filed May 12, 2017; effective June 26, 2017.

Repealed: Filed January 22, 2019.

Rule No. 560-X-62-.13 Quality Assurance Committee

- (1) Pursuant to Section 22-6-154 of the Alabama Code, the Medicaid Agency shall have a quality assurance 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 physicians who provide care to Medicaid beneficiaries served by a regional care organization.
 - c. In making appointments to the committee, the Medicaid Commissioner shall seek input from the appropriate 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 subsections 10(d) and 11(e) of this rule. The alternate shall be of the same profession as the absent member for whom the alternate is selected.

- (2) The committee shall identify objective outcome and quality measures, including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care, and all other health services provided by regional care organizations.
- (3) Quality measures adopted by the committee shall be consistent with existing state and national quality measures.
- (4) The Medicaid Commissioner shall incorporate outcome and quality measures into regional care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements.
 - a. The committee shall adopt outcome and quality measures annually and adjust the measures to reflect the following:
 - i. The amount of the global budget for a regional care organization.
 - ii. Changes in membership (RCO enrolled population) of the organization.
 - iii. The organization's costs for implementing outcome and quality measures.
 - iv. The community health assessment and the costs of the community health assessment conducted by the organization.
- (5) The Medicaid Agency shall continuously evaluate the outcome and quality measures adopted by the committee.
- (6) The Medicaid 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.
- (7) The Medicaid Agency shall publish the information collected under this section at aggregate levels that does not disclose information otherwise protected by law. The information published shall report, by regional care organizations, all of the following:
 - a. Quality measures.

- b. Costs.
 - c. Outcomes.
 - d. Other information, as specified by the contract between the regional care organization and the Medicaid Agency, that is necessary for the Medicaid Agency to evaluate the value of health services delivered by a regional care organization.
- (8) Except as otherwise provided in rules promulgated by the Medicaid Agency, the Medicaid Quality Assurance Committee shall not participate in the data validation or performance evaluation of regional care organizations by the Medicaid Agency.
- (9) The Medicaid Quality Assurance Committee shall select a Committee Chair and a Committee Co-Chair, who shall each reside in different regions.
- (10) The Medicaid Quality Assurance Committee shall meet at least annually to approve the regional care organization outcome and quality measure set for the upcoming calendar year.
- a. A quorum of at least fifteen (15) Medicaid Quality Assurance 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 (50 percent +1 member) of those present and eligible to vote.
 - c. If approved by the Committee Chair, a committee member may participate and/or vote in a meeting of the committee by means of telephone conference, videoconference, or similar communications equipment by means of which all persons participating in the meeting may hear each other at the same time. Participation by such means shall constitute presence in person at a meeting for all purposes, including the establishment of a quorum.
 - d. In the event that a Medicaid Quality Assurance Committee member is unable to participate in a Medicaid Quality Assurance 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.

- (11) The performance standards and quality measures reviewed or developed by a regional care organization's Provider Standards Committee shall be subject to the approval of the Quality Assurance Committee in accordance with Section 22-6-151 (h) and the procedures set forth in Rule No. 560-X-62-.09.
- a. No member of the Medicaid Quality Assurance Committee who also served on a provider standards committee which developed a performance standard or quality measure that is at issue shall vote or participate in the Medicaid Quality Assurance Committee's review of that performance standard or quality measure.
 - b. A quorum of at least fifteen (15) Medicaid Quality Assurance Committee members (or their selected alternates) shall be required to take such action on behalf of the Committee.
 - c. The Committee shall approve or disapprove outcome and quality measures based on a simple majority vote (50 percent +1 member) of those present and eligible to vote
 - d. 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 constitute presence in person at a meeting for all purposes, including the establishment of a quorum.
 - e. In the event that a Medicaid Quality Assurance Committee member is unable to participate in a Medicaid Quality Assurance 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.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 *et seq*; 42 CFR Part 438.

History: New Rule: Filed August 11, 2014; effective September 15, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.14 Quality Assurance Process

- (1) The Medicaid Agency shall have a regional care organization performance monitoring and improvement process that includes at a minimum:

- a. The review of monthly, quarterly and annually-reported quality and performance data, including outcomes and quality measures adopted by the Medicaid Quality Assurance Committee, regional care organization operational and administrative measures, CMS-required performance standards and other measures as deemed necessary by the Medicaid Agency in its contract with a regional care organization and/or in rules promulgated by the Medicaid Agency to manage the regional care organization program.
- b. At least quarterly, a meeting with the executive director, medical director and others as determined by the Medicaid Agency from each regional care organization to share performance results, discuss performance successes and challenges and determine the effectiveness of quality improvement activities
- c. At least annually, a meeting with the Medicaid Quality Assurance Committee to adopt the recommended regional care organization outcome and quality measure set for the upcoming calendar year. Prior to the annual meeting, the Medicaid Agency shall distribute performance reports and other materials, as necessary, to assist Committee members with evaluating the effectiveness of outcome and quality measures and determining whether to change the regional care organization outcome and quality measure set. The Medicaid Agency shall also conduct telephonic, webinar or in-person meetings with the Medicaid Quality Assurance Committee, as necessary, to discuss performance results.
- d. At least annually, a meeting with each regional care organization's provider standards committee to share that regional care organization's performance results for the purpose of determining the effectiveness of provider performance standards and quality measures. This meeting may be conducted by telephonic, webinar or in-person means.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 *et seq*; 42 CFR Part 438.

History: New Rule: Filed August 11, 2014; effective September 15, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.15 Right to Terminate Certificates of Probationary and Fully Certified Regional Care Organizations

(1) The certificate of an organization as a probationary regional care organization or as a full regional care organization (referred to collectively 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 22-6-150, *et seq.* of the Alabama Code or rules promulgated by the Medicaid Agency.

(2) In the event of termination by the Medicaid Agency, a written notice of termination shall be sent to the organization.

(3) The Medicaid Agency may terminate a certificate based on an organization's failure to timely file required reports and updated information as required by Rules 560-X-62-.05(20) and 560-X-62-.06(9) or otherwise required by the Medicaid Agency after reasonable written notice with an opportunity to cure is provided by the Medicaid Agency.

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

(5) The Medicaid Agency may terminate a certificate for the failure on the part of the organization to meet and/or maintain the solvency and other financial requirements set forth in Section 22-6-151 of the Alabama Code and rules promulgated by the Medicaid Agency.

(6) The Medicaid Agency may terminate a certificate should it reasonably determine that the continued operation of the organization 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 organization.

(7) Notwithstanding any provisions of this rule, the Medicaid Agency may terminate an organization'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 organization and/or any of its officers and directors.

(8) The organization may request a fair hearing in writing if it is not satisfied with the termination action.

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

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 *et seq*; 42 CFR Part 438.

History: New Rule: Filed August 11, 2014; September 15, 2014. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.16 Solvency and Financial Requirements for Regional Care Organizations

(1) Subject to Section 22-6-159(c) of the Alabama Code, each organization with probationary regional care organization certification ("probationary RCO") shall, not later than October 1, 2015, have demonstrated to the Medicaid Agency's approval that it has met or will

meet the solvency and financial requirements for a regional care organization ("RCO") as outlined in section (2) of this rule.

(a) A probationary RCO shall be deemed to have met such requirements if the Medicaid Agency has in its discretion approved one or more of the following: (i) irrevocable letters of commitment to provide the required capital or surplus and restricted reserves from one or more risk bearing participants with a demonstrated ability (as determined by the Agency in its sole discretion) to provide the required funds, (ii) a commitment letter from a qualified insurer to issue a performance bond complying with section (3) of this rule, (iii) evidence satisfactory to the Medicaid Agency demonstrating that the probationary RCO has adequately funded a restricted reserve account in accordance with section (4) of this rule and has satisfied the capital or surplus requirement, (iv) the probationary RCO's most recent audited financial statements reflecting the required capital or surplus and restricted reserves, or (v) some combination of (i) through (iv) satisfactory to the Medicaid Agency.

(b) No organization shall be granted full RCO certification until it has either (i) provided a balance sheet, certified by the chief executive officer and chief financial officer of the RCO, reflecting the capital or surplus required pursuant to section (2) of this rule (subject to confirmation and validation by the Medicaid Agency) and evidence satisfactory to the Medicaid Agency demonstrating that the RCO has adequately funded a restricted reserve account in accordance with section (4) of this rule, or (ii) provided a performance bond in accordance with section (3) of this rule.

(2) Each RCO shall meet at a minimum the solvency and financial requirements provided in this section or section (3) of this rule. Each RCO, as a condition of certification or continued certification, and as a condition to the risk contract between the Medicaid Agency and the RCO, shall maintain minimum financial reserves at the following levels:

(a) Restricted reserves of two hundred fifty thousand dollars (\$250,000) or an amount equal to 25 percent of the RCO's total actual or projected average monthly expenditures (as calculated pursuant to section (5) of this rule), whichever is greater; and

(b) Capital or surplus, or any combination thereof, of two million five hundred thousand dollars (\$2,500,000).

(3) Instead of maintaining the financial reserves required by section (2) of this rule, an RCO may submit to the Medicaid Agency a written guaranty in the form of a bond issued by an insurer, in an amount equal to the aggregate financial reserves that would otherwise be required of the RCO under section (2), to guarantee the performance of the provisions of the risk contract, satisfying the following requirements:

(a) The performance bond shall be issued by an insurer authorized to do business in the State of Alabama and approved by the Medicaid Agency.

(b) No assets of the RCO shall be pledged or otherwise encumbered in connection with the performance bond.

(c) The performance bond shall be approved by the Medicaid Agency as to form and content and shall be payable to the Medicaid Agency on demand in the event of the Medicaid Agency's determination in its sole discretion that the RCO is in default under the risk contract, with no proof of breach or default required.

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

(4) Each RCO other than RCOs satisfying their financial reserves requirements with a performance bond 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 RCO's restricted reserve funds required pursuant to subsection (2)(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-62-18 that the RCO is insolvent, is in a hazardous financial condition, or is otherwise in default under the risk contract.

(b) Each RCO shall provide a copy of its executed model depository agreement to the Medicaid Agency in accordance with the timeline for implementation set forth in Section 22-6-159 of the Alabama Code and such model depository agreement shall remain in effect throughout the term of the risk contract, including any renewals thereof, unless and until the RCO provides a performance bond in compliance with section (3) 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 RCO's required restricted reserves pursuant to subsection (2)(a) of this rule, an RCO's average monthly expenditures shall be equal to the average monthly total capitated payment pursuant to the RCO's risk contract. Thus, the restricted reserves required to be maintained by an RCO shall be the greater of \$250,000 or 25% of such average monthly total capitated payment. "Average monthly total capitated payment" means the

mathematical average of the total capitated 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 RCO's required restricted reserves shall be adjusted based on the average monthly total capitated payment for such preceding quarter. Until an RCO has completed a full calendar quarter of its risk contract, the RCO's projected average monthly total capitated payment shall be determined by the Medicaid Agency, based on a projection of the capitated payment to be paid to the RCO if the Medicaid Agency enters into a risk contract with the RCO. 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 RCO's risk contract, based upon changes in the projected or the actual capitated payment under the risk contract.

(6) For purposes of subsection (2)(b) of this rule and Section 22-6-151(e) of the Alabama Code, an RCO's capital and surplus is the difference between the admitted assets of the RCO and the liabilities of the RCO, determined as follows:

(a) The classification and value of the RCO's assets and liabilities shall be determined in accordance with Generally Accepted Accounting Principles (GAAP), as modified by the provisions of this section (6).

(b) For purposes of this rule, "admitted assets" means only assets owned exclusively by the RCO 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 capitated payments pursuant to the risk contract between the RCO and the Medicaid Agency or, in the case of an RCO granted probationary RCO certification, due or deferred payments for case management services;

(vi) The amount recoverable under any stop loss insurance or reinsurance provided or approved by the Medicaid Agency, and the amount recoverable from a third party reinsurer if and to the extent credit for stop loss insurance or reinsurance is allowed by the Medicaid Agency;

(vii) The acquisition cost of land and depreciated cost of improvements thereon owned by the RCO 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 RCO; and

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

(c) In addition to assets not described in subsection (6)(b) of this rule, an RCO'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 RCO'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 RCO, liabilities to be charged against the RCO's admitted assets shall include, in addition to other liabilities chargeable in accordance with GAAP:

(i) The amount necessary to pay all of the RCO'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 (2)(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 Rule No. 560-X-62-.18 or otherwise required by applicable law.

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

(8) The Medicaid Agency may offer or mandate that each RCO participate in one or more stop-loss insurance or reinsurance programs, including but not limited to one or more stop-loss pools. The Medicaid Agency may administer any such programs and may require that they be funded by the RCOs at such levels as may be determined by the Medicaid Agency. If the Medicaid Agency offers or mandates a stop-loss insurance or reinsurance program, no RCO shall purchase duplicative stop loss insurance or reinsurance for enrollees that provides the same coverage as that offered or mandated in such stop-loss insurance or reinsurance program.

(9) Each RCO shall at its expense procure and maintain, throughout the term of the risk contract between the Medicaid Agency and the RCO, professional and general liability

insurance, directors' and officers' liability insurance, errors and omissions liability insurance, and, if the RCO provides Medicaid services to enrollees directly, medical malpractice insurance, in such amounts and including such coverage as set forth in the risk contract.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed March 20, 2015; effective April 24, 2015. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.17 Financial Reporting and Audit Requirements

(1) Each regional care organization ("RCO") shall provide to the Medicaid Agency a periodic financial report setting forth information concerning the RCO'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 RCO 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 RCOs use specific reporting forms in order to supply required information.

(2) Each RCO 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 RCO which could result in a determination of hazardous financial condition or insolvency pursuant to Alabama Administrative Code Rule 560-X-62-.18, including but not limited to any deficiency in the required restricted reserves or capital and surplus of the RCO, the RCO 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 RCO.

(4) Each RCO shall at its expense have its independent certified public accountant deliver directly to the Medicaid Agency the certified audited annual financial statements of the RCO, prepared in accordance with generally accepted accounting principles (GAAP), no later than 120 days after the RCO's fiscal year end, for the immediately preceding fiscal year. The Medicaid Agency may require that supplemental financial information be included in the RCO'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 RCO'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 RCO's independent certified public accountant, the Medicaid Agency shall conduct or contract for audits of each RCO, in

accordance with Section 22-6-153(h)(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 RCO, 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.

(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 RCO that is the subject of the audit.

(d) The RCO shall produce or provide timely, convenient, and free access at all reasonable business hours at the offices of the RCO 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 RCO. The officers, directors, and agents of the RCO shall facilitate the audit.

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

(i) Not later than 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 RCO, its agents, affiliates, or other persons being examined or information from testimony of individuals concerning the affairs of the RCO, 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 RCO that is the subject of the audit and shall give the RCO an opportunity to review and respond to the audit report. The Medicaid Agency may request additional information or meet with the RCO 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 RCO has had an opportunity to review and respond to the report.

(iii) If the final audit report reveals that the RCO 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 RCO 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 RCOs, the Medicaid Agency may at any time require any RCO to produce such books and records in the possession of the RCO or its affiliates or risk-bearing participants as are reasonably necessary to ascertain the financial condition of the RCO or to determine compliance with the rules of the Medicaid Agency and the contract between the RCO and the Medicaid Agency. If the RCO 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 RCO 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 RCO and the Medicaid Agency. The Medicaid Agency shall report the failure to comply to all of the RCO's participating providers. The RCO 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 RCO'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) All books, documents, payroll papers, accounting records, and other evidence pertaining to costs incurred under each contract between an RCO and the Medicaid Agency will be maintained and made available by the RCO at reasonable times during business hours during the period of the agreement and for five years thereafter for inspection by any authorized representatives of the state or federal government, or for such longer period as may be required by contract or applicable state or federal law.

(9) 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: Sharon Weaver, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 et seq. 42 C.F.R. Part 438.

History: New Rule: Filed March 20, 2015; effective April 24, 2015. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.18 Hazardous Financial Condition and Insolvency

(1) A regional care organization ("RCO") shall be deemed to be in a hazardous financial condition if the continued operation of the RCO is determined by the Medicaid Agency to be hazardous to the RCO'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 RCO 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 RCO's payments to providers;
- (b) Adverse findings reported in financial condition examination reports, audit reports, or actuarial opinions, reports or summaries;
- (c) Whether the RCO 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 RCO, when considered in light of the assets held by the RCO 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) The inability of a a stop loss insurance carrier or assuming reinsurer to perform, other than stop loss insurance or reinsurance administered by the Medicaid Agency;
- (e) Whether the RCO's operating losses in the last 12-month period or any shorter period of time is greater than 50 percent of the RCO's remaining capital and surplus in excess of the minimum required;
- (f) Whether a risk-bearing participant which has contributed cash, capital, or other assets to the RCO, or a guarantor, surety, insurer, reinsurer, 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 RCO, 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 RCO;
- (g) 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 RCO;
- (h) An adverse change in the age and collectability of receivables other than from the Medicaid Agency;
- (i) Whether the management of an RCO, including officers, directors or any other person who directly or indirectly controls the operation of the RCO, fails to possess and demonstrate the competence, fitness and reputation determined by the Medicaid Agency to be necessary to serve the RCO in such position;

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

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

(l) Whether management or any other agent of an RCO 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 RCO;

(m) Whether the RCO 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;

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

(o) 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;

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

(q) Any significant monetary judgment or fine filed against the RCO or any significant civil or criminal action brought against or concluded adversely to the RCO.

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

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer or stop loss carrier that is insolvent, impaired or otherwise subject to a delinquency proceeding;

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

(c) Increase the RCO's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the RCO 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 RCO and the Medicaid Agency, and applicable state and federal law, if the Medicaid Agency determines that an RCO is in a hazardous financial condition, the Medicaid Agency may in its discretion require the RCO to do one or more of the following:

(a) Reduce the total amount of present and potential liability for enrollee benefits by reinsurance or stop loss insurance;

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

(c) Increase the capital and surplus of the RCO above the level required by Rule No. 560-X-62-.16;

(d) Increase the restricted reserves of the RCO above the level required by Rule No. 560-X-62-.16;

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

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

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

(h) 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;

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

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

(4) An RCO 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 No. 560-X-62-.16 or this rule and the Medicaid Agency declares that the RCO is insolvent. If the Medicaid Agency determines that an RCO is insolvent, the Medicaid Agency shall give notice of the insolvency to all of the RCO'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 RCO 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 RCO;

(b) Allow the RCO 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 RCO; and

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

(6) The RCO 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 RCO is insolvent, is in a hazardous financial condition, or is otherwise in default under the risk contract between the Medicaid Agency and the RCO, the Medicaid Agency may, in addition to its other rights and remedies, access and disburse the RCO's restricted reserves for the payment of providers in accordance with terms of the Model Depository Agreement provided by the Medicaid Agency.

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

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

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

(c) Covered services provided to the enrollee, for which the Medicaid Agency or the RCO 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 RCO 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 RCO, including without limitation calling for payment under any performance bond securing the RCO'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 RCO if the Medicaid Agency has made a finding described in 42 CFR § 438.706 permitting or requiring the imposition of temporary management.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 et seq. 42 C.F.R. Part 438.

History: New Rule: Filed March 20, 2015; effective April 24, 2015. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.19 Requirements for Full Certification of Regional Care Organizations

(1) An organization seeking full certification as a regional care organization (referred to herein also as “applicant”) shall be incorporated as a nonprofit corporation under Alabama law. The certificate of formation of the organization shall mandate 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.

(2) In order to seek full certification as a regional care organization the applicant must submit a Medicaid approved application for full certification and provide such documentation required by the Medicaid Agency pursuant to Sections 22-6-150, *et seq.* of the Alabama Code and rules promulgated by the Medicaid Agency

(3) Except as otherwise set forth herein or prescribed in Section 22-6-150, *et seq.* of the Alabama Code and rules promulgated by the Medicaid Agency, the applicant must have met the following timeline and/or benchmarks:

(a) The applicant must have established by no later than October 1, 2014, or as otherwise allowed, a governing board and structure acceptable to the Medicaid Agency as provided in Section 22-6-150, *et seq.* of the Alabama Code and Rules No. 560-X-62-.03 and 560-X-62.05.

(b) The applicant must have demonstrated to the Medicaid Agency’s satisfaction and approval by no later than April 1, 2015, the ability to establish an adequate medical service delivery network that meets the requirements of Rule No. 560-X-62-.12 and federal access standards set forth in 42 CFR §§ 438.206 - 438.210.

(c) The applicant must have demonstrated to the Medicaid Agency’s satisfaction and approval by no later than October 1, 2015, that it has met solvency and

financial requirements for a regional care organization as required by Section 22–6–150, *et seq.* of the Alabama Code and Rules No. 560-X-62-.16, 560-X-62-.17, and 560-X-62-.18 by the Medicaid Agency.

(d) The applicant must have demonstrated to the Medicaid Agency's satisfaction and approval by no later than May 1, 2016, that it is capable of providing services pursuant to a risk contract to be effective October 1, 2016 as provided in Rule 560-X-62-.22.

(e) The timelines and benchmarks set forth in this subsection shall not preclude the applicant from seeking full certification earlier than the dates set forth herein provided it has demonstrated to the Medicaid Agency's satisfaction and approval that it has met such requirements.

(f) Notwithstanding the above, failure by the applicant to timely meet one or more of the benchmarks set forth in this subsection shall not prevent the Medicaid Agency, at its sole discretion, from granting full certification to the organization as long as it meets all of the benchmarks by October 1, 2016.

(g) Failure to meet and maintain any one of the benchmarks set forth in this subsection shall constitute grounds for denial of an application for full certification.

(4) The Medicaid Agency shall have the power to approve the members of the governing board of the applicant and any organizational and governing documents, which may exist, such as the applicant's articles of incorporation, articles of formation, bylaws, operating agreement, certificate of formation, rules, trust agreements, confidentiality agreements, organizational minutes and/or minutes appointing or designating persons as officers, directors, managers or resolutions 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. All appointments of and to committees and all delegations of authority by the organization shall satisfy the requirements of Sections 22-6-150, *et seq.* of the Alabama Code and all other requirements under Alabama law.

(5) The governing body of an organization granted full certification as a regional care organization 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 of health care services delivery, quality improvement and utilization review programs including biannual meetings at a minimum for the purpose of evaluation and improvement of the health services of the organization and to respond to recommendations and findings of the quality improvement 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 health services. All records must be maintained for not less than five (5) years;

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

(6) The applicant must have established a citizen's advisory committee for the Medicaid region the applicant plans to serve that meets and maintains the requirements of Section 22-6-151(d) of the Alabama Code and Rule No. 560-X-62-.04.

(7) The applicant must be able to demonstrate it meets and maintains the minimum solvency and financial requirements required by Section 22-6-151 of the Alabama Code and Rule No. 560-X-62-.16. The applicant shall also provide such additional financial reports and information as required by the Medicaid Agency and Section 22-6-151(f) of the Alabama Code sufficient to demonstrate to the Medicaid Agency that the organization meets the required solvency and financial requirements.

(8) The applicant must promptly notify the Medicaid Agency of any substantial or material changes in the corporate structure, governance or financial condition of the organization since the time it was granted a certificate for probationary certification. The Medicaid Agency may request additional documentation and information regarding such changes.

(9) The applicant must be current and in good standing with all reporting requirements mandated by rules promulgated by the Medicaid Agency.

(10) The applicant must describe to the Medicaid Agency's satisfaction and approval the demonstrated experience and capacity of the organization and/or its collective principals, officers and directors for managing financial risk, establishing financial reserves, maintaining sufficient net worth and/or adequate solvency and the past experience or expertise of the applicant and/or its collective principals, officers and directors in working as part of a medical service delivery network.

(11) The applicant must demonstrate to the Medicaid Agency's satisfaction and approval that it has created a provider standards committee that meets the requirements of Section 22-6-151(h) of the Alabama Code and Rule No. 560-X-62-.09.

(12) The applicant must demonstrate to the Medicaid Agency's satisfaction and approval that it has adopted policies and procedures for review of provider contract disputes that meet the requirements of Section 22-6-153(g) of the Alabama Code and Rule No. 560-X-62-.11.

(13) The applicant must demonstrate that it has adopted appropriate policies, procedures and forms, approved by the Medicaid Agency, to assist enrollees and potential enrollees in their enrollment, disenrollment, filing grievances and appeals and as is otherwise needed to assist in understanding the rights, obligations, benefits and requirements of participating in the integrated and coordinated health delivery system set forth in Section 22-6-150, *et seq.* of the Alabama Code. The organization's policies, procedures and forms must satisfy Rule No. 560-X-62.-21 and 42 CFR 438.10.

(14) The applicant must demonstrate to the Medicaid Agency's satisfaction and approval that it is organized in a manner consistent with the accomplishment of its stated mission, which shall include, at a minimum, delivery of Medicaid covered health care services in accordance with Sections 22-6-150, *et seq.* of the Alabama Code.

(15) The applicant must demonstrate to the Medicaid Agency's satisfaction and approval its strategy to identify appropriate delivery systems and reimbursement methods in order to align incentives in support of integrated and coordinated health care delivery throughout the Medicaid region the organization seeks to serve.

(16) All applications for full certification as a regional care organization (hereafter "applications") must include the following information or documentation for the Medicaid Agency's review and approval:

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

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

(c) The name, mailing address, email 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, medical director and/or administrator of the applicant and any other persons responsible for the healthcare services of the applicant, 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 Medicaid region the applicant seeks to serve;

(g) Identification of the applicant's Certificate to Collaborate Number issued by the Medicaid Agency; and

(h) Copies of current organizational and governing 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 or other documents creating an executive committee or other committee and/or appointing members thereto, management services agreements, administrative services agreements, conflict of interest policies and all other similar or applicable documents and agreements regulating the conduct of the internal affairs of the applicant and all amendments thereto, which may exist.

(17) All applications shall also include the following information concerning the applicant's governing board of directors for each Medicaid region the organization plans to serve 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 if applicable;

(c) Documentation and information demonstrating the amounts, levels and/or 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 Medicaid region;

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

(i) is himself/herself a risk bearing participant or that he/she represents a risk bearing participant in the organization as described in Section 22-6-151(c)(1) of the Alabama Code, and the nature of his/her participation as a risk bearing participant. If he or she is a risk bearing participant or represents a risk bearing participant, detailed information concerning the profession or occupation, qualifications, training, expertise, experience and demonstrated abilities of the board member;

(ii) is a medical professional who provides care to Medicaid beneficiaries in the region and, if so, whether such individual is a primary care physician, an optometrist, or a pharmacist. The applicant shall certify that the medical professionals are appointed by the associations or organizations identified in Section 22-6-151 (c)(1)(b) of the Alabama Code and

(iii) is a community representative qualified, elected or appointed consistent with Section 22-6-151(c)(1)(c) of the Alabama Code.

(f) With respect to each board of directors member, background information pertaining to any adverse action against any occupational, professional or vocational license or permits; 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 members of the board of directors do not and will not represent a single provider. Alternatively, certification that only one entity has offered to be a risk-bearing participant in the organization as defined in Section 22-6-151(c)(1) of the Alabama Code;

(h) Certification that six of the twelve risk-bearing participants required on the governing board of directors shall be “primary medical providers,” “core specialists” and/or “facilities” as defined in subsections (1)(a)-(c) of Rule No. 560-X-62-.12 , or representatives thereof, who treat Medicaid beneficiaries in the region to be served by the organization.

(18) All applications shall also include the following information concerning its citizen’s advisory committee for each Medicaid region the organization plans to serve for the Medicaid Agency’s review and approval:

(a) The name, occupation, mailing address, email address, and telephone number of each member of the citizen’s advisory committee;

(b) Information evidencing that the membership of the citizen’s advisory committee is inclusive and reflects the racial, gender, geographic, urban/rural and economic diversity of the region and the members of its citizen’s advisory committee;

(c) A description of the method the organization used to select the members of its citizen’s advisory committee;

(d) Identification of the members of the citizen’s advisory committee who are Medicaid beneficiaries who reside in the Medicaid region the organization plans to serve. It shall be applicant’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;

(e) Identification of the members of the citizen’s advisory committee who are representatives of organizations that are part of the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations.

(19) All applications 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 on behalf of the organization has been and will continue to be in good faith and consistent with Section 22-6-163 of the Alabama Code;

(b) that such bargaining 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 to citizens who are Medicaid eligible at the lowest possible cost;

(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;

(g) that the applicant intends to provide services to Medicaid beneficiaries in all counties of each Medicaid region the organization plans to serve;

(h) any other requirements set forth in rules promulgated by the Medicaid Agency.

(20) All agreements and contracts of the applicant shall be subject to review and/or approval by the Medicaid Agency pursuant to Section 22-6-163(d) of the Alabama Code.

(21) All financial reports and information requested from the applicant shall be subject to review and/or approval by the Medicaid Agency.

(22) 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 at any time to verify that the applicant will implement the Medicaid laws and regulations in accordance with the legislative intent and to engage in appropriate state supervision necessary to promote state action immunity under applicable law.

(23) 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 regional care organization 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 medical service delivery network, potential funding sources, organizational issues and other topics may be discussed.

(24) In determining whether an organization should be granted full certification as a regional care organization, The Medicaid Agency shall consider, in addition to criteria set forth in the RCO statutes and applicable state and federal regulations, the application, the results of the readiness assessment review and documents submitted in connection therewith, the results of any review by the Centers for Medicare and Medicaid Services, and any additional documentation and information it considers relevant, including but not limited to the following:

(a) Composition of the board of directors, including but not limited to the professions, qualifications, training, expertise, experience and demonstrated abilities of the risk bearing members, including which members are providers or representatives of providers to Medicaid beneficiaries and the types of providers;

(b) The amounts, levels and/or types of financial risk of all risk-bearing participants and directors in the organization. To be a risk bearing board member, the capitated contract and/or contribution of cash, capital or other assets contributed by the risk-bearing participant must be meaningful;

(c) The organizational structure and makeup of each organization as well as the persons and entities involved in each organization as members, owners, risk bearers or otherwise involved in the formation, ownership, structure, management, control and operation of the organization;

(d) The number of providers or representatives of providers on the executive committee and other committees; and

(e) Whether certification of such organization is believed by the Medicaid Agency to be in the best interest of the State and consistent with the requirements and legislative intent of Section 22-6-150, *et seq.* of the Alabama Code.

(25) If the Medicaid Agency, in its sole discretion, determines that the applicant meets all the requirements for full certification, the Medicaid Agency shall issue the organization a certificate as a regional care organization.

(26) If a probationary regional care organization contracts with the Agency to perform case management services in accordance with Section 22-6-162 of the Alabama Code and Rule 560-X-62-.07, a failure to perform such services to the Agency's satisfaction may be grounds for denial of organization's application for full certification.

(27) The applicant shall promptly notify the Medicaid Agency of any substantial or material corrections or updates to the information provided in connection with its application. The applicant shall also promptly notify the Medicaid Agency of any vacancy and subsequent filling of any vacancy on the governing board of directors and of any appointments of an executive committee and members appointed thereto.

(28) All applications submitted pursuant to this rule, all Certificates as a Regional Care Organization, and the names and addresses of all applicants and their officers, directors and contact persons to whom the Medicaid Agency issues Certificates as a Regional Care Organization 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.

(29) Any person or entity may notify the Medicaid Agency of conduct of an applicant or a board of director's member that is alleged to violate any of the certifications by the applicant 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 deny an application and may terminate certificates to collaborate and an organization's certificate for full or probationary certification upon finding that the applicant or the board of director's member has failed to comply with applicable laws or regulations or any of the certifications required from the applicant or the board of director's member pursuant to rules promulgated by the Medicaid Agency or may, in its sole discretion, impose any other terms, conditions, and/or sanctions determined necessary to effectuate the objectives of Certification.

(30) Whenever an application is denied, the applicant 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.* A written request for a fair hearing must be received by the Medicaid Agency within thirty calendar days from the date the notice of action is mailed. The Medicaid Agency will not accept requests for fair hearings which are outside the thirty day limit.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 *et seq.* and Section 41-22-1, *et seq.*; 42 C.F.R. Part 438

History: New Rule: Filed March 20, 2015; effective April 24, 2015. **Amended:** Filed July 13, 2015; effective August 17, 2015. **Amended:** Filed March 11, 2016; effective May 26, 2016. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.20 Grievances and Fair Hearings of Regional Care Organizations

(1) A regional care organization (RCO) with a grievance concerning the Medicaid Agency as addressed in Section 22-6-153(e) of the Alabama Code, shall abide by the following procedures.

(2) For the purposes of this rule, a “RCO grievance” means any dispute or claim of a RCO 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 RCO shall request a fair hearing with the Medicaid Agency to review an RCO grievance. The request for fair hearing must be in writing and must be filed with the Medicaid Agency within 60 calendar days from the date of the occurrence upon which the RCO 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 RCO 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 60 calendar days from the RCO’s receipt of such audit, reconciliation, or report. An RCO’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 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 RCO’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 RCO 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 RCO may also request an informal conference with the Medicaid Agency to seek a resolution of the RCO grievance.

(5) If the RCO grievance is not resolved through informal conference with the Medicaid Agency, the RCO 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.* The hearing authority for all fair hearings of RCO 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 RCO grievance. The hearing officer shall not have been involved in any way with the RCO 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 RCO’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 10 calendar days before the hearing is to be held. The notice shall comply with the requirements of Section 41-22-12(b).

- (7) The RCO may be represented at the fair hearing by legal counsel at its own expense. The RCO 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, unless otherwise noted in this rule. Within 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 30 calendar days of the recommendation. The Medicaid Agency shall promptly send a copy of the final decision to the RCO's address of record by certified mail.
- (10) The RCO 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.
- (11) This rule shall not be applicable to any grievance relating to a provider contract subject to the provisions of Section 22-6-153(g) or Rule No. 560-X-62-.11.
- (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: Sharon Weaver, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 *et seq.* and 41-22-12 through 41-22-19.

History: New Rule: Filed March 20, 2015, effective April 24, 2015. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.21 Information Requirements for Enrollees and Potential Enrollees

- (1) Duty to Provide Information to Enrollees and Potential Enrollees
- (a) Regional Care Organizations and alternate care providers (hereinafter collectively referred to as "organizations") shall adopt policies and procedures designed to clearly and thoroughly explain the process to enroll in an organization, the rights and responsibilities of enrollees, the grievance and appeals process and the requirements and benefits of the integrated and coordinated health care delivery system implemented pursuant to Section 22-6-150, *et seq.* of the Alabama Code.
- (b) As used in this section, "enrollee" means a Medicaid beneficiary enrolled as a member of an organization. As used herein "potential enrollee" means a Medicaid

beneficiary subject to mandatory enrollment in an organization or who may voluntarily or be required to enroll as a member of an organization, but is not yet enrolled in an organization.

(c) The organization shall have written policies, procedures and forms approved by the Medicaid Agency that provide the type of information required herein and that satisfy applicable state and federal law, including but not limited to, 42 CFR 438.10. The organization shall have an ongoing process of participating provider and enrollee education and information sharing designed to effectuate the provisions of this rule. Information for potential enrollees must comply with the marketing prohibitions in 42 CFR 438.104.

(d) Organizations shall ensure that all organization representatives who have contact with enrollees and potential enrollees are properly trained and fully informed of the policies, procedures, and forms of the organization applicable to enrollment, disenrollment and the grievance system set forth under the RCO laws and regulations.

(e) The organization must provide all forms, enrollment notices, informational materials and instructional materials in a manner and format that may be easily understood. The organization must have policies and procedures in place designed to assist enrollees and potential enrollees in making informed decisions and in understanding the organization's forms, policies and procedures, as well as the benefits and services provided by the organization.

(f) Within 15 calendar days of an organization receiving notice of an enrollee's enrollment in the organization, the organization shall mail an information packet to new enrollees setting forth the information required herein. The packet shall include, at a minimum, confirmation of enrollment in the organization, an enrollee handbook and a participating provider directory. Alternatively, enrollees may elect but are not required to receive the organization's materials electronically via e-mail, an on-line enrollee portal, or similar means. An organization wishing to make this option available must contact the enrollee within 5 business days of enrollment to determine if the enrollee prefers to receive information electronically. For enrollees who make this election, the organization must mail written confirmation within 15 calendar days of an organization receiving notice of an enrollee's enrollment in the organization confirming the enrollee's decision to receive information electronically and explaining the method(s) for doing so and how to opt-out and return to paper communications.

(i) The directory shall list by specialty the names, addresses and telephone numbers of all participating providers for the provider types required by the Medicaid Agency.

(ii) The handbook, participating provider directory, as well as forms, policies and procedures provided by the organization pursuant to this rule, shall also be maintained on the organization's website.

(iii) After enrollment, the organization shall upon request provide enrollees the enrollee handbook and a current participating provider directory, in print or online, depending on the request.

(iv) At least once a year the organization shall provide notice to enrollees that the handbook and directory are available upon request.

(v) The handbook shall list the organization's location, mailing address, web address, telephone number and office hours.

(vi) The participating provider directory must be updated at least quarterly.

(vii) The organization shall also provide to enrollees within 15 calendar days an identification card which contains easily understood information on how to access care in an urgent or emergency situation. The enrollee identification card shall also contain the enrollee name, contractor identification number, if applicable, the name and contact information of enrollee's primary care physician and the organization's toll free number.

(2) Language. The organization must at a minimum:

(a) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the region served by the organization. "Prevalent" means a non-English language spoken by five (5) percent or more of potential enrollees and enrollees in the region.

(b) Make available written information in each Prevalent non-English language.

(c) Make oral interpretation services available free of charge to each potential enrollee and enrollee in all applicable non-English languages.

(d) Notify enrollees and potential enrollees that oral interpretative services are available for any language and that written information is available in Prevalent languages and how to access those services.

(3) Format. Written material required to be provided to enrollees and potential enrollees must use easily understood language, not to exceed a fifth (5th) grade reading level, and format. The material must be available in alternative formats and in an appropriate manner that takes into consideration special needs of those with visual impairments and/or with limited reading proficiency. Enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

(4) Information for Potential Enrollees. In addition to any requirements on the part of the State or its participating provider, upon ten business days of a request, the organization must provide potential enrollees documents approved by the Medicaid Agency that adequately describes:

- (a) The basic features of the RCO program;
- (b) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- (c) The responsibilities of the organization for coordination of care; and
- (d) Information specific to the organization operating in the potential enrollee's service area, including:
 - (i) Benefits covered;
 - (ii) Cost sharing, if any;
 - (iii) Service area; and
 - (iv) Names, locations and telephone numbers of Non-English language spoken by current participating providers, including identification of those not accepting new patients, including at minimum information on contracted primary care physicians, specialists and hospitals.
- (e) Benefits available under the State Plan that are not covered services in the organization's network, including how and where the enrollee may obtain those benefits, any cost sharing and how transportation may be provided. For counseling or referral services the organization or its participating providers do not cover because of moral or religious objections, information must be provided for how and where to obtain the service.

(5) Information for Enrollees. The organization must provide information required by 42 CFR 438.10(f) and hereunder to all enrollees including:

- (a) Within ten calendar days of request, the organization must notify enrollees of their disenrollment rights.
- (b) The right of enrollees to request and obtain the information listed herein at least once a year.
- (c) The right of enrollees to request the information listed herein within a reasonable time after the organization receives notice of the enrollee's enrollment in the RCO program.

(d) Written notice of any significant changes in the information required under this rule provided at least 30 days before the intended effective date of the change.

(e) The organization must make a good faith effort to provide written notice of termination of a participating provider, within 15 days after receipt or issuance of the termination notice to the participating provider, to each enrollee who received his or her care from, or was seen on a regular basis by, the terminated provider.

(f) Names, locations, telephone numbers of non-English languages spoken by current participating providers in the enrollee's service area, including identification of participating providers that are not accepting new patients. At a minimum, this must include information on participating primary care physicians, specialists and hospitals.

(g) Any restrictions on the enrollee's freedom of choice among network providers.

(h) Enrollee rights and protections set forth in 42 CFR § 438.100.

(i) Information on grievances and appeals required by rule(s) promulgated by the Medicaid Agency.

(j) The amount, duration and scope of benefits available under the contract between the organization and the Medicaid Agency in sufficient detail to ensure that enrollees understand the covered services to which they are entitled.

(k) Procedures for obtaining benefits, including authorization requirements.

(l) The extent to which, and how, enrollees may obtain covered services, including family planning services, from out of network providers.

(m) How, when and where after hours coverage, urgent care services and emergency coverage are to be provided as required by 42 CFR 438.10(f)(6)(viii).

(n) Information on available post-stabilization care as required by 42 CFR 422.113(c).

(o) Information on cost sharing, co-payments, charges for non-covered services, and the enrollee's possible responsibility for payments for services if he/she goes outside of the region for non-emergent care.

(p) Information on contracted hospitals in the enrollee's service area and, unless otherwise provided, the enrollee has a right to use any hospital or other setting for emergency care.

(q) Information on advance directive policies.

(r) How to access information on participating providers accepting new enrollees in an organization.

(s) How to access and understand forms provided by the organization and how to obtain assistance in completing and submitting forms.

(t) The enrollee's right to request and obtain copies of their clinical records and whether they may be charged a reasonable copying fee.

(6) Grievances and appeals. The organization must provide information to enrollees advising of their rights to file grievances and appeals and of their rights to a hearing pursuant to Section 22-6-153 of the Alabama Code and Rule No. 560-X-62-.19. The organization must provide information which at a minimum advises enrollees:

(a) The right to file a grievance and the time frame and process for which to do so.

(b) The process and time frame for which notices of action are to be provided.

(c) The rights to file an appeal of an action and the process and time frame for which to do so.

(d) The availability of assistance in the filing process and the type of assistance available.

(e) An enrollee's right to hearings and timeframes, rules and procedure related thereto.

(f) The toll free numbers that the enrollee can use to file a grievance or an appeal by phone or seek interpretive assistance by phone.

(g) That when requested by the enrollee, covered services may continue if the enrollee files a timely appeal and that the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

(h) The other rights and obligations of the enrollee set forth in Rule No. 560-X-62-.19.

(7) Compliance with state and federal law. In addition to the information required by this rule, the organization must provide an enrollee and potential enrollee any additional information required by applicable state and federal law and that may be required in a risk contract between the organization and the Medicaid Agency. All such information must be provided in a format required by applicable law or in the risk contract.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 *et seq.* 42 C.F.R. Part 438, 42 C.F.R Part 422.

History: New Rule: Filed March 20, 2015; effective April 24, 2015. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.22 Readiness Assessment Requirements

(1) Each organization that intends to enter into a risk contract with the Medicaid Agency shall be subject to a readiness assessment period. The readiness assessment period shall commence on January 1, 2015 and shall conclude with the Medicaid Agency's award or denial of full regional care organization certification to the organization.

(2) The Medicaid Agency will provide draft(s) of a risk contract to any organization seeking full regional care organization certification. Upon the Medicaid Agency's request, the organization will have forty-five (45) days to submit a written plan and other necessary documentation describing the organization's readiness to satisfy requirements of the Medicaid Agency in the areas set forth below and as may otherwise be required by Section 22-6-150, *et seq.* and rules promulgated thereunder:

(a) April 1, 2015 – Demonstrate the ability to establish an adequate medical service delivery network.

(b) October 1, 2015 – Demonstrate compliance with the solvency and financial requirements for a regional care organization

(c) May 1, 2016 – Demonstrate ability to provide services pursuant to a risk contract to be effective October 1, 2016 including development and readiness to operate:

- (i) Key Staffing
- (ii) Governance
- (iii) Provider Services and Materials
- (iv) Network Adequacy
- (v) Claims Processing and Payment
- (vi) Solvency and Audit
- (vii) Financial
- (viii) Care Coordination
- (ix) Quality Management
- (x) Grievance and Appeals
- (xi) Requirements Related to Enrollees
 - (A) Enrollment
 - i. Disenrollment
 - ii. Enrollee Services
 - iii. Information Requirements

- (B) Marketing, Outreach and Member Materials
- (xii) Administrative Support
- (xiii) Technical Infrastructure
 - (A) Management Information Systems (MIS)
- (xiv) Utilization Management
- (xv) Compliance and Oversight
- (xvi) Other Requirements as requested by the Medicaid Agency pursuant to final RCO Contract

(3) Upon the Medicaid Agency’s approval of the organization’s written plan, the Medicaid Agency will provide a readiness assessment tool detailing the requirements necessary to demonstrate the organization’s readiness to fulfill the obligations of a risk contract. The Medicaid Agency will conduct a readiness review which will include desk and onsite reviews of information submitted by the organization.

(4) All requested documentation, information and/or demonstrations must be submitted or conducted as specified by the Medicaid Agency. The Medicaid Agency may require additional documentation or updates to submissions throughout the readiness assessment period.

(5) The organization shall produce or provide timely, convenient, and free access at reasonable business hours at the offices of the organization to all books, records, accounts, papers, documents, and electronic and other recordings in its possession or control relating to the matter related to the readiness assessment, including as applicable the property, assets, business and affairs of the organization.

(6) The organization shall make private office space available to the Medicaid Agency and its contractors for the duration of any onsite review without cost to the Medicaid Agency or its contractors.

(7) The organization’s final submission of the readiness assessment tool and all required documents will serve as the organization’s submission of the report required by Rule No. 560-X-62-.06(5)(c).

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed March 20, 2015; effective April 24, 2015. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.23 Grievances and Appeals of Medicaid Enrollees in Regional Care Organizations and Alternate Care Providers

(1) This rule is promulgated pursuant to Section 22-6-153 (d) of the Alabama Code to establish a grievance and appeal system consisting of a grievance process, appeal process, and access to the Medicaid Agency’s fair hearing system (the “grievance system”) for enrollees in a

regional care organization or an alternate care organization (hereafter collectively referred to in this rule as “organization”).

(2) For the purposes of this rule an “enrollee” in an organization shall be construed to mean a Medicaid beneficiary currently enrolled in an organization, or a provider authorized in writing on a Medicaid Agency approved form to act on behalf of an enrollee, and any other person authorized in writing on a Medicaid Agency approved form or by court order to act as a representative on behalf of an enrollee who has filed a grievance or appeal pursuant to this rule (all of whom shall be collectively referred to in this rule as “enrollee”).

(3) For the purposes of this rule a “grievance” means an expression of dissatisfaction by an enrollee about any matter related to the enrollee’s care and treatment by the organization in accordance with 42 CFR 438.400. A grievance does not include matters that constitute an “action” under the following subsection 5 or any matter that may be in litigation.

(4) An enrollee may submit a grievance orally or in writing to the organization within 5 business days of learning of the basis of the grievance. A grievance may only be filed with the organization. The organization must acknowledge receipt of the grievance within 5 business days, consider each enrollee grievance and, provide notice of the resolution of the grievance as expeditiously as the enrollee’s health condition requires and in any event no more than 30 calendar days from receipt of the grievance. The organization must assign a person(s) not directly involved in the matter that is the subject of the grievance to conduct a reasonable review of the circumstances surrounding the grievance. The reviewer shall review any relevant parts of the enrollee’s case file and medical records as well as all documents submitted on behalf of the enrollee and may, as it deems necessary, conduct additional investigation into the grievance and/or consult with medical or behavioral professionals. The response to the grievance by the organization shall be in writing and fully explain the decision reached as to each part of the grievance presented and the reasons for the decision. Enrollees have no right to appeal an adverse determination of a grievance. The failure on the part of an organization to act on a grievance as required by this section shall constitute an action under subsection 5.

(5) For the purposes of this rule an “action” means action the organization has taken or plans to take that could result in a material change or limitation to enrollee’s care and treatment including but not limited to the approval or denial of care, adverse decisions related to billing and payment or bundling matters, and other decisions related to the provision of health care services offered, made available or denied to the enrollee by the organization that constitutes an action under 42 CFR 438.400. For the purposes of this rule “the provision of health care services” shall include, but not be limited to, the denial or limited authorization of a claim or requested service, including the type or level of service; the reduction, suspension, or termination of an authorized service; the total or partial denial of payment for a service; the failure to provide services in a timely manner as required by state or federal law or rules of the Medicaid Agency; the failure of an organization to act within timeframes established by the Medicaid Agency or within the timeframes provided in 42 CFR 438.408(b); or in applicable cases, the denial of an enrollee’s request to exercise his or her right to obtain services outside of the delivery network of the organization. For the purposes of this rule, an appeal shall be construed to mean the request for review of an “action.”

(6) (a) In the event the organization takes or decides to take an action (as defined herein) regarding an enrollee, a written “notice of action” shall be provided to the enrollee as expeditiously as possible but whenever possible not less than 10 calendar days before the date of any proposed action that would involve termination, suspension or reduction of a previously authorized covered service, unless the delay resulting from such a notice is reasonably believed to be injurious to enrollee’s health and welfare by enrollee’s treating physicians or except as otherwise required by § 438.404(c). The notice shall be sent by mail to enrollee’s last known address and may also be communicated to enrollee by email or facsimile transmission. All such notices of action must at a minimum, clearly and thoroughly explain, on forms approved by the Medicaid Agency:

(1) The action the organization has taken or proposes to take and when;

(2) The reasons for the action taken or proposed;

(3) The full rights of appeal the enrollee has to challenge the action under the provisions of this rule and Section 22-6-153 (d), including but not limited to the right to seek an expedited appeal in certain cases;

(4) The procedures an enrollee must follow to exercise his/her rights to appeal;

(5) The enrollee’s right to request and receive a continuation of benefits pending resolution of the appeal, the process to request continuation of benefits and the circumstance under which the enrollee may later be required to pay for the services continued during appeal; and

(6) The time by which all appeals must be filed by the enrollee.

(b) The period of advanced notice is shortened to five (5) calendar days if probable enrollee fraud has been verified.

(c) The period of notice shall be the date of the action for the following:

i. In case of the death of an enrollee;

ii. A signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services (where he or she understands that this must be the result of supplying that information);

iii. The enrollee’s admission to an institution where he or she is ineligible for further services;

iv. The enrollee’s address is unknown and mail directed to him or her has no forwarding address;

v. The enrollee has been accepted for Medicaid services by another local jurisdiction; and

vi. The enrollee's physician prescribes the change in the level of medical care.

(d) Pursuant to 42 CFR 438.404(c)(2), when the notice of action is a denial of payment, the organization shall provide enrollee written notice on the date of the action.

(e) Pursuant to 42 CFR 438.210(c), the organization must notify the requesting provider of any decision to deny a service authorization request or of any decision to authorize a service in amount, scope or duration that is less than requested. The notice need not be in writing but must meet the requirements of 42 CFR 438.404.

(7) The enrollee may within 20 calendar days of receipt of notice of an action file an appeal orally or in writing of the action before the medical director of the organization, who shall be a primary care physician. The enrollee shall state in the notice of appeal whether oral hearing is requested. An oral notice of appeal must be confirmed in writing within 3 calendar days.

(a) The medical director must send the enrollee notice of receipt of the appeal within 3 calendar days. The acknowledgment shall state when the enrollee's appeal will be decided, which, except as otherwise provided herein, shall be no later than 10 calendar days from the date of filing of the notice of appeal. In the event enrollee requests an oral hearing, that hearing shall be no later than 20 calendar days of filing the notice of appeal.

(b) The organization shall immediately provide the medical director all relevant parts of enrollee's case file and medical records and any information submitted by enrollee.

(c) Within 5 calendar days of filing the notice of appeal, enrollee shall submit to the medical director all written materials the enrollee would like to be considered. The medical director shall consider all relevant parts of the enrollee's case file and medical records as well as any additional material submitted on behalf of the enrollee. If oral hearing has been requested in the notice of appeal, the enrollee shall have an opportunity to present evidence, allegations of fact and law, as well as arguments, in person, writing or by telephone, at the election of enrollee.

(d) The rules of evidence shall not apply.

(e) The medical director's decision shall be binding on the organization and must be provided to enrollee orally or in writing within 1 calendar day of resolution of enrollee's appeal. Oral notices of the resolution must be confirmed in writing within 2 additional calendar days on a form approved by the Medicaid Agency. The written notice of the decision shall state in reasonable detail the basis for the decision.

(8) If the enrollee is dissatisfied with the decision of the medical director, the enrollee may within 10 calendar days of notification of the decision file a written or oral notice of appeal with the organization to be heard by a peer review committee of the organization. An oral appeal must be confirmed in writing within 5 calendar days.

(a) The peer review committee shall be composed of at least three physicians who have the same specialty as the ordering or prescribing physician and who work within the region

in which the services or matter is at issue. If three physicians cannot be found to serve who work within the region served by the organization, then the positions may be filled by physicians of the same specialty who work outside of the region.

(b) The organization shall send enrollee acknowledgment of receipt of the appeal within 3 calendar days of receipt of the notice. The acknowledgment shall state when the enrollee's appeal will be heard, which shall be no less than 7 and no more than 21 calendar days of the filing of the notice of appeal.

(c) The organization shall provide the peer review committee all relevant parts of enrollee's case file and medical records and all other information submitted by enrollee.

(d) The peer review committee shall consider all relevant parts of the enrollee's case file and medical records along with any additional material submitted on behalf of the enrollee.

(e) The enrollee shall have the right to present arguments, evidence, and allegations of fact or law in person, writing or by telephone.

(f) The rules of evidence shall not apply.

(g) The peer review committee's decision shall be sent to enrollee within 14 calendar days of the hearing on appeal on a form approved by the Medicaid Agency and be binding on the organization.

(h) A peer review committee formed pursuant to Section 22-6-153 (d) and this rule shall be separate and distinct from a peer review committee created pursuant to Administrative Rule 560-X-2-.01 et seq. and not subject to the provisions of that rule.

(9) If the enrollee is dissatisfied with the decision of the peer review committee, the enrollee may within 20 calendar days of notice of the decision submit a notice of appeal to the Medicaid Agency on a form approved by the Medicaid Agency. The enrollee shall also submit a copy of the notice of appeal to the organization on the same date. Timely oral requests shall be permitted so long as the oral request is reduced to writing within 48 hours. In the event an enrollee files a notice of appeal with the organization instead of the Medicaid Agency, the organization shall forward such request to the Medicaid Agency within two business days of receipt.

(a) The Medicaid Agency shall within 10 calendar days of receipt of the notice of the appeal provide the enrollee written notice of such receipt and of the date and time the appeal will be heard by the Medicaid Agency. The appeal shall be heard no sooner than 10 calendar days or any longer than 30 calendar days from the date of the notice setting the date and time of appeal. Hearings may be continued for up to 14 calendar days at the request of the enrollee, or for good cause shown, at the request of the regional care organization. For extensions not requested by the enrollee, the organization must provide the enrollee prompt written notice of the reason for the delay and the extension must be in the enrollee's best interest.

(b) The Medicaid Agency shall request the following information from the organization which must be provided within 14 calendar days from the filing of the notice of appeal:

- i. A copy of the relevant parts of enrollee's case file and medical records; and
- ii. All documents considered by or presented to the medical director and the peer review committee and the decisions rendered by each.

(c) The enrollee shall be entitled to review all such information before and during the hearing on enrollee's appeal.

(d) The enrollee shall be afforded a full evidentiary hearing in the region in which the enrollee resides.

(e) The parties to the appeal shall be the regional care organization and the enrollee. The enrollee may represent himself/herself before the Medicaid Agency or have someone else appear on enrollee's behalf in person, by telephone or in writing at the election of the enrollee and be provided a reasonable opportunity to present arguments, evidence and allegations of fact or law.

(f) A record must be made of the hearing and the organization shall be responsible for the cost.

(g) The Medicaid Agency will send to the enrollee and the provider a written finding of the decision within 15 calendar days of the hearing before the Medicaid Agency stating with specificity the basis for the decision as well as all matters considered in reaching the decision which shall be binding upon the regional care organization.

(10) If the enrollee is dissatisfied with the decision rendered by the Medicaid Agency, enrollee may file an appeal to the circuit court in the county in which the enrollee resides, or the county in which the provider provides the services at issue to the enrollee. The enrollee must file the appeal in circuit court by no later than 30 calendar days after receipt of the decision rendered in connection with the appeal to the Medicaid Agency.

(11) Each organization must have written policies and procedures approved by the Medicaid Agency that clearly and fully explain an enrollee's right to file grievances and appeals of actions, as well as forms approved by the Medicaid Agency for filing grievances and appeals pursuant to sections (7) and (8) of this rule. Any material changes to such policies and procedures must be approved by the Medicaid Agency and copies provided to enrollees and providers in writing at least 30 calendar days prior to implementation.

(a) All policies, procedures and forms required herein shall meet the requirements of 42 CFR §438.10 and Medicaid Agency Administrative Rule No. 560-X-62-.21. The rights of enrollees to file grievances and appeals, the process to do so, and the required forms shall be posted on the website of the organization and provided to the enrollee within 60 days of enrollment. Such documents shall also be provided to providers when provider contracts are entered into.

(b) Each organization must maintain a toll free number for enrollees to use to orally submit a grievance or notice of appeal. The toll free number must be available during normal business hours.

(c) The organization must cooperate with the enrollee and provide reasonable assistance as needed to explain and complete forms and take other procedural steps related to the filing of grievances and appeals, including but not limited to providing free interpreter services.

(d) At each stage of the appeals process the organization, or the Medicaid Agency in the event of an appeal pursuant to Section 9 hereof, shall:

- i. Timely acknowledge in writing receipt of the notice of appeal and state the date, time and process by which the appeal is to be heard and decided;
- ii. Advise enrollee or his/her provider or duly appointed representative of the enrollee's rights on appeals including the right to examine the enrollee's file, medical records and all other information considered or submitted by the organization; and
- iii. Advise enrollee of the right to request benefits while the appeal is pending and that the enrollee may in such case be held liable for the cost of those benefits if the appeal is not decided in favor of enrollee.

(e) The organization may not discourage any enrollee from using any aspect of the grievance system set forth in this rule nor encourage the withdrawal of a grievance, appeal or hearing request filed pursuant to this rule. The organization may not use the filing or resolution of a grievance, appeal or an action or hearing request as a reason to retaliate against the enrollee or provider or as a basis to seek disenrollment of the enrollee. The right of an enrollee to file a grievance or appeal and the rights of an enrollee during the grievance and appeal process shall be fully set forth in the Provider Manual and Enrollee Handbook supplied to all providers and enrollees by the organization.

(12) Each grievance and appeal submitted pursuant to this rule must be appropriately considered and timely resolved in accordance with the following:

(a) The organization shall ensure that persons making decisions in connection with any grievance or appeal were not involved in any previous level of review or decision-making regarding the matters at issue. The organization shall ensure that appropriate healthcare professionals participate in all decisions in which (i) the grievance or appeal involves clinical issues; (ii) the appeal is of a denial of a request based on lack of medical necessity, or (iii) a grievance is received regarding denial of a request for an expedited appeal.

(b) All decisions rendered as part of any grievance or appeal filed on behalf of an enrollee shall be in writing, clearly state the decision reached and fully explain the reasons for the decision and documents and criteria considered in rendering the decision.

(c) The organization shall, if requested by the enrollee, provide reasonable assistance to help the enrollee understand the decision rendered and if necessary provide an interpreter to assist the enrollee.

(d) At each level of the grievance and appeal process set forth herein in which a decision is rendered that is adverse to enrollee, the enrollee shall be advised in writing by the organization (or by the Alabama Medicaid Agency in the event of an appeal pursuant to section 9 of this rule) of any rights of appeal provided the enrollee pursuant to Section 22-6-153(d) and under this rule. All such notices shall comply with the requirements of 42 CFR § 438.10(c) and (d) and Rule No. 560-X-62-.21.

(e) The organization must provide written notice of disposition of the appeal, which notice must include:

1. The results of and date of the resolution of the appeal.
2. For decisions not wholly in the enrollee's favor:
 - i. The right to request further appeal;
 - ii. How to request further appeal;
 - iii. The right to continue to receive benefits pending an appeal;
 - iv. How to request the continuation of benefits; and
 - v. If the action taken by the organization is upheld on appeal, the enrollee may be liable for the cost of any continued benefits.

(13) Consistent with rules promulgated by the Medicaid Agency and otherwise required by law, the enrollee's right to confidentiality shall be maintained as much as practical through each step of the grievance and appeal system taking into consideration the need for disclosure of medical and other information necessary to resolve enrollee's grievance or appeal, to determine payments or benefits that may be due and/or to evaluate quality of care by the organization or the effectiveness of the grievance system established by the organization. By participating in the grievance system provided for in this rule the enrollee will be deemed to have consented to the release of his/her medical records to the extent necessary in order to act upon enrollee's grievance or appeal and shall execute any necessary releases for such disclosure.

(14) Notwithstanding anything herein to the contrary, an enrollee shall have the right to request an expedited appeal to the organization that would not follow the standard time for appeals otherwise set forth in this rule, if following the standard time for appeal could reasonably be expected to seriously jeopardize the enrollee's life or health or the ability to attain, maintain or regain maximum function. The request may be filed orally or in writing after which no additional enrollee follow-up is required.

(a) When a request for expedited appeal is received the enrollee must be advised within 2 business days of receipt of the request whether such request is accepted or denied.

(b) If the expedited appeal is accepted, the enrollee must be advised within 2 business days of receipt of the request of the limited time available in such case for the enrollee to present evidence, present or question witnesses, present allegations of fact or law and to appear in person, writing or by telephone.

(c) In the case of an expedited appeal pursuant to this section an enrollee shall be advised of the decision on enrollee's appeal orally or in writing within 3 business days of receipt of the request for expedited appeal. Regardless of any written notice, reasonable efforts must be made to provide oral notice within 3 business days. Written confirmation of any oral notice shall be sent within an additional 2 business days.

(d) If the decision is made to deny an expedited appeal the enrollee shall be advised orally within twenty-four hours and also in writing within 2 business days of the request after which the standard review and appeals process outlined in this rule shall apply.

(e) The expedited appeal process may be extended by up to 14 calendar days if requested by the enrollee or if the organization determines that there is need for additional information and that the delay is in the interest of the enrollee.

(f) If the extension requested by the organization is granted, the enrollee must be promptly notified in writing of the extension and the reason for the extension.

(g) The organization must ensure that punitive action by the organization is not taken against an enrollee or provider who requests an expedited resolution.

(15) (a) During each appeal provided for herein, the organization must continue the enrollee's covered benefits if:

- i. the enrollee files the notice of appeal timely;
- ii. the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- iii. the services were ordered by an authorized provider;
- iv. the original period covered by the original authorization has not expired; and
- v. the enrollee requests extension of benefits.

(b) If, at the enrollee's request, the organization continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

- i. the enrollee withdraws the appeal;
 - ii. 10 calendar days pass after the organization mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10 calendar day timeframe, has requested an appeal and has requested a continuation of benefits until that decision is reached;
 - iii. a State fair hearing Officer issues a hearing decision adverse to the enrollee;
- and
- iv. the time period or service limits of a previously authorized service has been met.

(c) If the final resolution of the appeal is adverse to the enrollee, that is, upholds the organization's action, the organization may recover from the enrollee the cost of the services

furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR § 431.230(b).

(d) Pursuant to 42 CFR 438.424(a), if services were not furnished to the enrollee while the appeal was pending and the decision to deny, limit or delay services is reversed, the organization must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(e) Pursuant to 42 CFR 438.424(b), the organization must pay for disputed services in accordance with State policy and regulations if the decision of the organization to deny authorization of services is reversed and the enrollee received the disputed services while the appeal was pending.

(16) The regional care organization shall maintain a grievance log and copies of all grievances and appeals filed by an enrollee pursuant to this rule, as well as all decisions rendered in response, for at least 7 years.

(a) The organization shall review the grievance log for completeness and accuracy regularly, but at least quarterly, and monitor the outcomes of such grievances and appeals as part of its quality assurance responsibility. The organization's grievance log shall set forth at a minimum the enrollee's name, the date and a description of each grievance and matter appealed; the basis for each grievance and appeal; the enrollee's provider for the service at issue, if any; whether continuation of benefits were requested and provided in each instance; the total number of grievances and appeals; the dates responses to the grievance or appeal were provided to the enrollee; the date of decision by the organization; and the outcomes of the grievance and appeals.

(b) The organization shall file a report at least annually with the Medicaid Agency that fairly and accurately summarizes the information required to be set forth on the grievance log.

(c) The Medicaid Agency shall be entitled to review all documents in the possession of the organization related to such grievances and appeals as a means of monitoring quality of care and the effectiveness of the policies and procedures of the organization in responding to enrollee grievances and appeals.

(17) Notwithstanding any provisions of this rule to the contrary, an organization shall be governed by grievance system regulations which may be found in their entirety in 42 CFR Section 438 Subpart F 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. In addition, the Medicaid Agency may impose additional requirements for the grievance and appeal system in the risk contract executed with any organization.

(18) Should the Medicaid Agency reasonably conclude from the information provided that an organization has not established, maintained and enforced a grievance system that satisfies the provisions of this rule and Section 22-6-153(d), the Medicaid Agency shall require the

organization to immediately take appropriate corrective action. Failure to take appropriate corrective action after a reasonable opportunity to cure can lead to action brought by the Medicaid Agency against the organization, including but not limited to suspension or termination of its certificate as a regional care organization.

(19) In the event of any conflict or discrepancy between the provisions of this rule and the hearing rules set forth in Medicaid Administrative Rules 560-X-3-.01 through 560-X-3-.07, this rule shall control and the conflicting provisions of the other stated rules shall not apply.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 et seq., 42 C.F.R. Part 438, 42 C.F.R. Part 431.

History: New Rule: Filed April 10, 2015; effective May 15, 2015. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.24 Sanctions

(1) Bases for Imposition of Sanctions on RCOs. The Medicaid Agency may impose sanctions on a regional care organization (“RCO”) if the Medicaid Agency determines in its sole discretion that the RCO has violated an applicable federal or state law or regulation, the Alabama Medicaid State Plan, the risk contract between the Medicaid Agency and the RCO 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 RCO acts or fails to act as follows:

(a) fails substantially to provide medically necessary services that the RCO 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 22-6-150, et seq. of the Alabama Code or the rules promulgated thereunder.

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

(a) requiring the RCO 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 RCOs. If the Medicaid Agency in its sole discretion determines that an organization with probationary RCO certification has (in connection with the probationary RCO's preparation for full certification, performance of

services under the Medicaid Agency's Health Home program, or otherwise) acted or failed to act in a manner that is sanctionable against an RCO in accordance with this rule, the Medicaid Agency may (a) impose any applicable sanction described in section 2 of this rule against such probationary RCO, 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 RCO's application for full certification in accordance with Rule No. 560-X-62-.19. Without limiting the foregoing, the Medicaid Agency may impose sanctions against a probationary RCO 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 RCO:

(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 22-6-150, et seq. 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-62-.20, 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 RCO 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-62-.20 and not to any other outstanding sanctions imposed on the RCO 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 RCO with a pre-termination hearing to be conducted in accordance with the procedures for fair hearings set forth in Rule No. 560-X-62-.20. Prior to such pre-termination hearing, the Medicaid Agency will, in accordance with 42 C.F.R. § 438.710:

(a) give the RCO 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 RCO 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 RCO 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 RCO 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 RCO 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 RCO or probationary RCO. Without limiting the foregoing, if a probationary RCO or RCO has entered into a contract with the Medicaid Agency to perform services under the Medicaid Agency's Health Home program, the Medicaid Agency may impose applicable sanctions under this rule in addition to exercising remedies and imposing applicable sanctions and penalties pursuant to such contract. 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 RCO, probationary RCO, and/or any other person or entity for breach of contract or any other cause of action.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed September 2, 2015; Effective October 7, 2015. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.25 Surplus Notes

(1) The proceeds of a surplus note issued by an RCO in compliance with this rule shall be eligible to be reported as capital or surplus or restricted reserves required by Rule

No. 560-X-62-.16. Such a surplus note shall not be treated as a liability of the RCO for purposes of a determination of the amount of the capital and surplus of the RCO pursuant to the rules of the Medicaid Agency.

(2) A surplus note shall be repayable only out of the issuing RCO's capital and surplus in excess of the stated minimum capital and surplus set forth in the surplus note. For purposes of this rule, "stated minimum capital and surplus" means the amount of capital and surplus of an RCO which may not be used for payments of interest or principal of the surplus note and which amount must be at least 110% of the minimum capital and surplus required by Rule No. 560-X-62-.16. If an RCO has provided a performance bond to the Agency in compliance with Rule No. 560-X-62-.16, the portion of the penal sum of such performance bond that is properly allocable to the satisfaction of the RCO's capital and surplus requirements under Rule No. 560-X-62-.16 shall be deemed to constitute capital and surplus for purposes of this rule.

(3) Proceeds received by an RCO in respect of a surplus note must be in the form of cash or other admitted assets having readily determinable values and liquidity satisfactory to the Medicaid Agency.

(4) All surplus notes issued by an RCO are subject to the prior approval of the Medicaid Agency, regardless of amount, and an application therefor shall be filed at least 30 days prior to the proposed date of the issuance of the surplus note by the RCO.

(5) All payments of principal and interest by the RCO and all transfers of a surplus note by the note holder are subject to the prior approval of the Medicaid Agency regardless of amount. An application therefor shall be filed at least 30 days prior to the date of the proposed payment or transfer.

(6) The Medicaid Agency shall prescribe a maximum interest rate or rates for surplus notes issued by RCOs. Such maximum interest rate or rates may be variable or fixed and shall be commercially reasonable, as determined by the Medicaid Agency in its sole discretion. The Medicaid Agency may adjust the maximum interest rate or rates from time to time as it deems appropriate.

(7) No surplus note shall include any stated maturity of principal or any installment thereof sooner than the date that is 30 days after the latest date that the risk contract between the Medicaid Agency and the RCO could by its terms expire, including any extension periods. Any payment of principal of a surplus note, whether at the stated maturity thereof or prior thereto, shall require the approval of the Medicaid Agency in accordance with sections 5 and 8(e) of this rule. This section shall not prevent an elective prepayment of principal of a surplus note made in compliance with this rule and in accordance with the terms of the surplus note.

- (8) A surplus note must contain the following provisions:
- (a) The surplus note must be subordinated to the claims of enrollees, providers, and all other classes of creditors of the RCO, other than surplus note holders;
 - (b) The note holder may be paid only out of the portion of the RCO's capital and surplus that exceeds the stated minimum capital and surplus;
 - (c) The stated minimum capital and surplus shall be at least 110% of the minimum capital and surplus required by Rule No. 560-X-62-.16;
 - (d) The surplus note must have a stated rate of interest not higher than the applicable maximum interest rate in effect at the time of the issuance of the surplus note, as prescribed by the Medicaid Agency in accordance with section 6 of this rule; and
 - (e) All payments of principal and interest by the RCO and all transfers of the surplus note by the note holder shall be subject to the prior approval of the Medicaid Agency. The Medicaid Agency may withhold its approval of any payment of principal or interest or any transfer of a surplus note if and so long as the RCO is in material violation or breach of any provision of Sections 22-6-150, *et seq.* of the Alabama Code, the rules of the Medicaid Agency, or the risk contract between the Medicaid Agency and the RCO, as determined by the Medicaid Agency in its sole discretion.
- (9) For purposes of a determination of the amount of capital and surplus of an RCO pursuant to Section 22-6-151 of the Alabama Code and Rule No. 560-X-62-.16, surplus notes shall be accounted for as follows:
- (a) Interest shall not be recorded as a liability nor an expense until approval for payment of such interest has been granted by the Medicaid Agency. All interest, including interest in arrears, shall be expensed when approved for payment. Unapproved interest shall not be reported through operations, shall not be represented as an addition to the principal or notional amount of the instrument, and shall not accrue further interest, i.e. interest on interest.
 - (b) As of the date of approval of principal payment by the Medicaid Agency, the issuer shall reclassify such approved payments from surplus to liabilities.
 - (c) Costs of issuing surplus notes shall be charged to operations when incurred.
 - (d) Discount or premium, if any, shall be reported as a direct deduction from or addition to the face amount of the note. Such discount or premium shall be charged or credited concurrent with approved interest payments on the surplus note and in the same proportion or percentage as the approved interest payment is to the total estimated interest to be paid on the surplus note.
- (10) The written application for approval of the issuance of a surplus note shall include the following:

- (a) The nature and purpose of the transaction;
- (b) The identities of all parties to the transaction;
- (c) A list of each officer or director of the RCO who has a direct or indirect equity interest in the note holder or serves as an officer or director of the note holder, or who has any other direct or indirect pecuniary interest in the transaction, together with a description of each such interest;
- (d) A copy of any agreement between the parties relating to the transaction;
- (e) Evidence that the transaction will not adversely affect the interests of the RCO's enrollees or the State; and
- (f) Such other information as the Medicaid Agency may require.

(11) The written application for approval of the payment of interest or principal shall include at least the following:

- (a) The amounts of any payments between the parties to the transaction;
- (b) The identities of all parties to the transaction;
- (c) Evidence that the payment is appropriate considering the financial condition of the RCO;
- (d) A current financial statement dated not earlier than 60 days before the application date which demonstrates the existence of sufficient capital and surplus in excess of the stated minimum capital and surplus; and
- (e) A certification by the chief executive officer of the RCO that the RCO's current total capital and surplus is in such amount that payment as of the payment date will be only from capital and surplus in excess of the stated minimum capital and surplus and will not adversely affect the RCO's current financial condition.

(12) Applications for approval of the issuance, transfer, or payment of interest or principal of a surplus note must meet the following standards:

- (a) The terms shall be fair and equitable;
- (b) The books, accounts, and records of each party shall be so maintained as to clearly and accurately disclose the precise nature and details of the transaction;
- (c) The RCO's capital and surplus following a payment of interest or principal shall be in excess of the stated minimum capital and surplus, reasonable in relation to the RCO's outstanding liabilities, and adequate to satisfy its financial needs; and

(d) The RCO shall not be in material violation or breach of any provision of Sections 22-6-150, *et seq.* of the Alabama Code, the rules of the Medicaid Agency, or the risk contract between the Medicaid Agency and the RCO, as determined by the Medicaid Agency in its sole discretion. Notwithstanding anything in this rule to the contrary, the Medicaid Agency's approval of the issuance, transfer, or payment of interest or principal of a surplus note shall not constitute a determination by the Medicaid Agency that the RCO is in compliance with any law, regulation, or the risk contract, and the Medicaid Agency shall not be deemed to have waived any authority, right, or remedy by reason of any such approval.

(13) Notwithstanding anything in this rule to the contrary, the provisions of this rule concerning accounting for surplus notes issued by an RCO shall apply only with respect to a determination of the capital and surplus of an RCO pursuant to Section 22-6-151 of the Alabama Code and the rules of the Medicaid Agency. No provision of this rule is intended to affect an RCO's financial statements prepared in accordance with Generally Accepted Accounting Principles.

Author: Sharon Weaver, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed December 23, 2015; effective February 8, 2016. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.26 Active Supervision of Regional Care Organizations

(1) The Medicaid Agency shall actively monitor and supervise each regional care organization's ("RCO") activities including, but not limited to, key staffing, governance, provider services and materials, network adequacy, claims processing and payment, solvency, financial, care coordination, quality and/or utilization management, grievance and appeals, enrollment requirements, administrative support, technical infrastructure, compliance with reporting and legal requirements, the collective negotiations, bargaining, cooperation, and collaboration described in Section 22-6-150(4) of the Alabama Code and any other activities determined by the Agency. In addition to any other reports required by the Medicaid Agency, each RCO shall submit an on-line periodic report to the Medicaid Agency on the first business day of the months of June and December unless otherwise specified by the Medicaid Agency.

(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 22-6-163 of the Alabama Code, including the following information:

(a) A description of the RCO's activities during the reporting period, including a description of what entities and persons with whom the RCO engaged in collective negotiations, bargaining, contracting, or cooperation during the reporting period and any material decisions by the RCO's Board of Directors, Executive Committee, Citizens' Advisory Committee, Provider Standards Committee, or management or managing entity of the RCO;

(b) A description of any concerns or problems encountered in the collaborative, bargaining and contracting, operational, or administrative process during the reporting period;

(c) A description of the nature and scope of expected future activities of the RCO; and

(d) Information concerning any previously unreported changes to the RCO's Board of Directors, Executive Committee, Citizens' Advisory Committee, Provider Standards Committee or corporate structure during the reporting period, including any changes in board or committee membership, material changes in management services, agreements or conflicts of interest policies, and any amendments or other changes to the RCO's governing documents such as the RCO's articles of incorporation, articles of formation, bylaws, operating agreement, certificate of formation and policies or rules required by the Medicaid Agency;

(e) Information concerning contracts or agreements the RCO entered into or terminated during the reporting period;

(f) A description of any material changes in the operations, performance, service delivery networks, policies and procedures required by the Medicaid Agency or by law or the financial condition of the organizations and of any substantial litigation filed against the organization related to the delivery of healthcare services or that could have a substantial adverse financial effect on the organization; and

(g) Any additional information the Medicaid Agency may request.

(3) Each RCO must provide the Medicaid Agency any documents, data or records requested for the reporting period, including the following:

(a) Minutes of meetings of the RCO's Board of Directors, Executive Committee, Citizens' Advisory Committee and Provider Standards Committee during the reporting period and copies of all documents and presentations reviewed at such meetings;

(b) Documents evidencing or reflecting any changes to the RCO's Board of Directors, Executive Committee, Citizens' Advisory Committee, Provider Standards Committee or corporate structure during the reporting period, including any changes in board or committee membership and any amendments or other changes to the RCO's governing documents such as the RCO's articles of incorporation, articles of formation, bylaws, operating agreement, certificate of formation, policies or rules required by the Medicaid Agency;

(c) Upon the Medicaid Agency's request, any contracts or agreements the RCO entered into during the reporting period; and

(d) Any additional documents, data or records the Medicaid Agency may request.

(4) All periodic reports submitted by each RCO must also include a narrative analysis, based upon currently available information, explaining how the operation of the RCO has and will continue to:

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

(b) result in cost-containment in providing health care 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 22-6-150, *et seq.* of the Alabama Code.

(5) The RCO 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 22-6-163 of the Alabama Code.

(6) All agreements and contracts of the RCO shall be subject to review and/or approval by the Medicaid Agency. The Medicaid Agency shall have the ability to disapprove any agreement, contract or material decision of the RCO that does not accord with applicable laws and regulations or the legislative intent expressed in Sections 22-6-163 of the Alabama Code. Any RCO aggrieved by a final decision of the Medicaid Agency under this section may appeal that decision by following the procedures outlined in Rule 560-X-62-.20.

(7) In accordance with Section 22-6-163(k) of the Alabama Code, the Medicaid Agency shall actively monitor agreements approved by the Medicaid Agency to ensure that a collaborator's or RCO's performance under the agreement remains in compliance with the conditions of approval. Upon request and not less than annually, a collaborator or RCO shall provide the Medicaid Agency requested information regarding agreement compliance. The Medicaid Agency may revoke the agreement upon a finding that performance pursuant to the agreement is not in substantial compliance with the terms of the contract. Any entity or individual aggrieved by any final decision regarding contracts under Section 22-6-163 of the Alabama Code that are approved by the Medicaid Agency, or presented to the Medicaid Agency, may take direct judicial appeal as provided for judicial review of final decisions in the Administrative Procedure Act.

(8) The RCO'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 Rule 560-X-62-.02. The RCO's submittal of a periodic report in accordance with this rule does not relieve the RCO from the requirement to submit other reports in accordance with a risk contract, rules of the Medicaid Agency or applicable federal or state law or regulation.

(9) Each RCO shall participate fully in any surveys that the Medicaid Agency may conduct concerning payment and delivery reforms. Each RCO shall provide the Medicaid Agency or its designee all information and data requested in connection with such surveys.

(10) 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.

(11) All workplans, documents related to readiness assessment, business plans, documents containing sensitive business, financial, or proprietary information or other documents and information produced or provided by the RCO 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 RCO 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.

(12) 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 Certificate as a Regional Care Organization 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. Other sanctions may be imposed in accordance with Rule 560-X-62-.24.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.

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

History: New Rule: Filed June 10, 2016; effective July 25, 2016. **Repealed:** Filed January 22, 2019.

Rule No. 560-X-62-.27 Contracts with Additional Regional Care Organizations

(1) The Medicaid Agency shall follow the procedures outlined in this Rule in the event any of the following occurs:

- (a) A regional care organization with probationary or full certification (collectively referred to as RCOs) has its certification terminated in a Medicaid region;
- (b) No organization had been awarded full certification in a Medicaid region by the date established by the Medicaid Agency;
- (c) The Agency could not award a contract to a RCO in a Medicaid Region under the terms of Section 22-6-153 of the Code of Alabama;
- (d) A RCO failed to provide adequate service in a Medicaid Region pursuant to its risk contract with the Agency; or,
- (e) The Agency and a RCO have initiated termination procedures under the terms of the risk contract.

(2) If any of the events set forth in subsections (1)(a)-(e) occur, the Medicaid Agency may, in its sole discretion, offer any RCO, which it judges could successfully provide services in its initial region and an additional region or regions (Additional Region), the opportunity to serve Medicaid beneficiaries in both regions. In any of such events, the Medicaid Agency will send a notice of opportunity to serve Medicaid beneficiaries in the Additional Region (Notice of Opportunity) to all remaining RCOs in any region. The Notice of Opportunity shall include, at a minimum:

- (a) Identification of the Medicaid region in which the vacancy exists;
- (b) The Agency's anticipated timeline for implementation;
- (c) The deadline for notice to be sent to the Agency in writing of a RCO's interest in sponsoring an entity to serve beneficiaries in the Additional Region (Sponsor RCO);
- (d) The date of the proposed planning meeting described in section (3) below; and,
- (e) Any other items or factors the Agency deems relevant.

(3) The Medicaid Agency shall schedule a planning meeting to discuss the Notice of Opportunity with all RCOs that notify the Agency in writing of an interest in serving beneficiaries in the Additional Region. At the planning meeting, the Medicaid Agency shall discuss the Agency's proposed Eligible Responder criteria, described in section (4) below, and Application Process criteria, described in section (6) below.

(4) In order to participate in the Application process described in section (6) below, an entity must be an Eligible Responder. In order to be an Eligible Responder, an entity must meet the following criteria:

- (a) Demonstrate to the Medicaid Agency's satisfaction that the Sponsor RCO has the ability to successfully provide services in both its initial region and the Additional Region. In evaluating the demonstration, the Medicaid Agency shall take into consideration:

- (i) The Sponsor RCO's historic performance in operating and/or establishing an organization with probationary or full certification;
 - (ii) The stability of the Sponsor RCO's current or proposed program, including, but not limited to the RCO's financial solvency and the operation of a health home program, if applicable;
 - (iii) The Sponsor RCO's compliance with reporting requirements, corrective action plans, and state or federal laws and regulations, including any sanctions issued for non-compliance; and,
 - (iv) Any other facts or circumstances the Medicaid Agency deems relevant to its consideration;
- (b) Attend the planning meeting and all other meetings deemed by the Medicaid Agency, in writing, as mandatory for Eligible Responders;
- (c) Obtain a Certificate to Collaborate in accordance with Alabama Medicaid Administrative Code Rule 560-X-62-.01;
- (d) Establish a separate legal entity in the Additional Region with a corporate and governance structure approved by the Medicaid Agency. This structure, at a minimum, must include:
- (i) An organization incorporated as a nonprofit corporation under Alabama law. The Certificate of Formation of the organization shall mandate 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% of 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.
 - (ii) A Governing Board of Directors which shall be responsible for the establishment and oversight of the organization's business and affairs. The Medicaid Agency shall have the power to approve the members of the Governing Board of Directors of the organization and the board's structure, powers, bylaws, or other rules of procedure, as well as all amendments thereto. The Governing Board of Directors shall be composed of the following members:
 - (A) Six risk-bearing members who are "primary medical providers," "core specialists" and/or "facilities" as defined in Alabama Medicaid Administrative Code Rule 560-X-62-.12(1)(a)-(c), or representatives

thereof, who treat Medicaid beneficiaries in the Additional Region to be served by the organization;

- (B) Six risk-bearing members who are risk-bearing members of the Sponsor RCO (any risk-bearing member that could qualify under both subsection (A) and (B) will be counted in this subsection (B) only); and,
- (C) Eight non risk-bearing members in accordance with Section 22-6-151(c)(1)(b)-(c) of the Alabama Code and Alabama Medicaid Administrative Code Rule 560-X-62-.03(1)(b)(i)-(ii) or a timeline, acceptable to the Medicaid Agency, for obtaining the eight non risk-bearing members;
- (iii) A Citizens' Advisory Committee in accordance with Section 22-6-151(d) of the Alabama Code and Alabama Medicaid Administrative Code Rule 560-X-62-.04 or a timeline, acceptable to the Medicaid Agency, for forming the Citizens' Advisory Committee;
- (iv) A Provider Standards Committee in accordance with Section 22-6-151(h) of the Alabama Code and Alabama Medicaid Administrative Code Rule 560-X-62-.09 or a timeline, acceptable to the Medicaid Agency, for forming the Provider Standards Committee;
- (v) A conflict of interest policy consistent with Alabama Medicaid Administrative Code Rule 560-X-62-.08;
- (e) Demonstrate that the organization will be able to meet the minimum solvency and financial requirements of Section 22-6-151(e) of the Alabama Code and Alabama Medicaid Administrative Code Rule 560-X-62-.16, notwithstanding the timing requirements contained therein; and
- (f) Any other requirements established by the Medicaid Agency.

(5) On or before a date established by the Medicaid Agency, all interested entities must have completed and submitted to the Agency evidence of compliance with the required criteria for Eligible Responders. The Medicaid Agency, in its sole discretion, may deem one or more, if any, organization(s) meeting the criteria established in section (4) above as Eligible Responders that shall be permitted to participate in the Application Process described in section (6) below.

(6) Only organizations designated as Eligible Responders may participate in the Application Process established by the Medicaid Agency. This process shall include:

- (i) A readiness assessment process consistent with Alabama Medicaid Administrative Code Rule 560-X-62-.22, notwithstanding the timing requirements contained therein;

- (ii) Active supervision reporting on a periodic basis as specified in the Application Process, consistent with Alabama Medicaid Administrative Code Rule 560-X-62-.26;
- (iii) Meet the minimum solvency and financial requirements of Section 22-6-151(e) of the Alabama Code and Alabama Medicaid Administrative Code Rule 560-X-62-.16, notwithstanding the timing requirements contained therein
- (iv) Demonstration of an adequate service delivery network as outlined in Alabama Administrative Code Rule 560-X-62-.12 notwithstanding the timing requirements contained therein;
- (v) Obtaining full certification consistent with Alabama Administrative Code Rule 560-X-62-.19, notwithstanding the timing requirements contained therein; and,
- (vi) Any other criteria established by the Medicaid Agency.

(7) On or about the date specified in the Application Process, the Medicaid Agency, in its sole discretion, may offer to one or more Eligible Responders the opportunity to serve Medicaid beneficiaries in the Additional Region. The Medicaid Agency's determination shall be based on the organization(s)'s performance during the Eligible Responder period and Application Process and compliance with all established benchmarks, reporting requirements, and other mandatory elements. The Medicaid Agency may, within its discretion, contract with one or more RCOs that meet the requirements of this Rule and other applicable RCO laws if the Agency determines the contract to be in the best interest of the State and Medicaid beneficiaries.

(8) No legal or equitable rights or interests are created by a RCO attending the planning meeting, pursuing Eligible Responder status, participating in the Application Process, or otherwise engaging in the process described herein. Any RCO dissatisfied with a determination of the Medicaid Agency during any step of the process described herein may file a written request for reconsideration to the Agency within five business days of the determination for which reconsideration is requested. The Medicaid Agency shall respond to the request for reconsideration within a reasonable time period.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.

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

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