ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-37
MANAGED CARE

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560-X-37-.01 General.

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

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

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

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

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

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

(i) Ensure needed access to health care;

(ii) Provide health education;

(iii) Promote continuity of care;

(iv) Strengthen the patient/physician relationship; and

(v) Achieve cost efficiencies.

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

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

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

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

(d) Alabama Medicaid Administrative Code;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Author: Jerri Jackson, Director, Managed Care Division
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), attachment 2.1-A; Social Security Act, Title XIX, Section 1903(m)(2)(B); 42 C.F.R. Section 434.26, Section 434.6; Civil Rights Act of 1964, Titles VI and VII, as amended. The Federal Age Discrimination Act, Rehabilitative Act of 1973. The Americans with Disabilities Act of 1990.
History: Amended: May 15, 1991; April 15, 1992. **Amended:** Filed April 6, 1994; effective May 13, 1994. **Amended:** Filed August 12, 1994; effective September 17, 1994. **Amended:** Filed July 6, 1995;

effective August 12, 1995. **Repealed and Replaced:** Filed June 6, 1996; effective July 12, 1996. **Amended:** Filed November 8, 2001; effective December 13, 2001. **Amended:** Filed May 12, 2003; effective June 16, 2003. **Amended:** Filed August 13, 2013; effective September 17, 2013. **Amended:** Filed February 9, 2018; effective March 26, 2018.

560-X-37-.02 Primary Care Case Management (PCCM).

(1) Under this model of managed care, each patient/recipient is assigned to a primary medical provider (PMP) who is a physician who is responsible for managing the recipient's health care needs. This management function neither reduces nor expands the scope of covered services.

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

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

(2) Primary Medical Providers (PMP). PMPs are generally family practitioners, general practitioners, internists or pediatricians. If a patient's condition warrants, PMPs of another specialty may be assigned if he/she is willing to meet all contractual requirements. Patients may be assigned to the individual physician. Patients may be assigned to a group of physicians, if approved by the Medical Director.
Author: Latonda Cunningham, Associate Director, Patient 1st Program
Statutory Authority: Sections 1915(b)(1)(2)(3), (4); Sections 1902(a)(i), (10), (23) of the Social Security Act, 42 C.F.R. 431.55, 438.2, 440.168.
History: Amended: May 16, 1991; April 15, 1992. **Amended:** Filed April 6, 1994; effective May 13, 1994. **Amended:** Filed August 12, 1994; effective September 17, 1994. **Repealed and Replaced:** Filed June 6, 1996; effective July 12, 1996. **Amended:** Filed December 8, 1997; effective January 12, 1998. **Amended:** Filed November 8, 2001; effective December 13, 2001. **Amended:** Filed May 12, 2003; effective June 16, 2003. **Repealed:** Filed April 9, 2004; effective May 14, 2004. **New Rule:** Filed August 11, 2004; effective September 15, 2004. **Amended:** Filed January 11, 2018; effective February 25, 2018. **Amended:** Published November 30, 2020; effective January 14, 2021.

560-X-37-.03 Prepaid Inpatient Health Plans (PIHP).

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

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

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

1. Outpatient hospital services;

2. Laboratory and X-ray services;

3. Nursing Facility (NF) services;

4. Physician services;

5. Home health services;

6. Rural health clinic services;

7. FQHC services;

8. Early and periodic screening, diagnostic, and treatment (EPSDT) services; and

9. Family planning services.

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

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

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

(a) It is an inpatient care program.

(b) It is mandatory for Medicaid recipients, with the exception of recipients with Part A Medicare coverage and SOBRA adults who are enrolled in and receive inpatient care through the Maternity Care program in counties covered by the

PHP and children certified through the Children's Health Insurance Program (CHIP).

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

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

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

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

1. Bed and board

2. Nursing services and other related services

3. Use of hospital facilities

4. Medical social services

5. Drugs, biologicals, supplies, appliances and equipment

6. Certain other diagnostic and therapeutic services, and

7. Medical or surgical services provided by certain interns or residents-in-training.

8. Excluded are inpatient family planning services and inpatient emergency services.

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

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

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

1. Quality assurance and utilization review systems

2. Grievance systems

3. Systems to furnish required services, including utilization review

4. Systems to prove financial capability

5. Systems to pay providers of care

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

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

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

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

2. Review procedures by appropriate health professionals of the process, following the provision of health services.

3. Procedures for systematic data collection of performance and patient results. Procedures for interpretation of these data to the provider.

4. Procedures for making needed changes.

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

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

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

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

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

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, attachment 2.1-A; Social Security Act, Title XIX, Section 1905(a)(2)(3)(4)(5)(7)(9); 42 C.F.R. Section 434.30, Section 434.6(a)(4).
History: Amended: March 11, 1986, ER April 1, 1987; June 10, 1987. **Amended:** Filed April 6, 1994; effective May 13, 1994. **Amended:** Filed August 12, 1994; effective September 17, 1994. **Amended:** Filed July 6, 1995; effective August 12, 1995. **Repealed and Replaced:** Filed June 6, 1996; effective July 12, 1996. **Amended:** Filed December 9, 1996; effective January 13, 1997. **Amended:** Filed December 8, 1997; effective January 12, 1998. **Amended:** Filed May 12, 2003; effective June 16, 2003. **Amended:** Filed June 11, 2004; effective July 16, 2004.

560-X-37-.04 Health Maintenance Organizations (HMO).

(1) Health Maintenance Organizations (HMO) means any entity or corporation that undertakes to provide or arrange for basic health care services through an organized system which combines the delivery and financing of health care to enrollees. The organization shall provide physicians services directly through physician employees or under contractual arrangements with either individual physicians or a group of physicians. The organization shall provide basic health care services directly or under contractual arrangements. When reasonable and appropriate, the organization may provide physician services and basic health care services through other arrangements. The organization may provide, or arrange for, health care services on a prepayment or other financial basis.

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

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

also be required to participate in an Invitation to Bid process as directed by the Medicaid Agency.

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

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

(a) Description of services to be provided

(b) Marketing Plan and any marketing materials to be used by the Plan

(c) Quality Assurance Plan

(d) Enrollment Plan

(e) Education Plan

(f) Copy of Certificate of Authority

(g) Copy of Certificate of Need or letter of non-reviewability

(h) Examples of subcontract to be utilized by the plan

(i) Proposed enrollment sites

(j) Enrollment area

(k) Grievance procedures

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

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

(7) Enrollment

(a) In geographical areas that are served by a freedom-of-choice waiver, enrollment in an approved HMO is mandatory for those recipients included in the waiver. Recipients will have the opportunity to voluntarily enroll in an HMO during the open enrollment period, if applicable.

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

(8) Disenrollment

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

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

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

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

(e) Enrollees may be disenrolled for knowingly committing fraud or permitting abuse of their Medicaid card.

Disenrollment of this nature must be promptly reported to Medicaid and must be prior authorized by Medicaid.

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

(9) Marketing

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

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

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

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

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

(10) Grievance Procedures

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

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

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

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

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

(11) Quality Assurance

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

1. Goals and objectives;

2. Scope;

3. Specific activities;

4. Continuous activities;

5. Provider review; and

6. Focus on health outcomes.

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

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

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

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

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

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

(h) HMOs shall allow Medicaid's authorized representative, on an annual basis, to conduct an external independent quality review to analyze the quality of services furnished by the HMO to ensure adequate delivery of care. The results of the review

shall be made available to Medicaid, and upon request, to the Secretary of HHS, the Inspector General, and the Comptroller General.

(12) Records

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

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

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

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

(13) Reporting

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

1. Business transactions to include:

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

(ii) Any lending of money or other extension of credit between the HMO and a party in interest; and

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

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

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

2. Proposed changes to the marketing plan, procedures or materials;

3. Monthly enrollment data to include name, Medicaid number, payee number, and PCP assignment number;

4. Utilization data concerning enrollees in the Plan as required by contract;

5. Summaries of all complaints and all grievances received by the HMO under this contract and actions taken to resolve complaints and grievances quarterly and annually.

6. Summaries of amounts recovered from third parties for services rendered to enrollees under the HMO;

7. A list of payments made by the HMO during the past month services purchased through referral and subcontracted providers;

8. Encounter data claims submitted directly to Medicaid's fiscal agent for all services paid for or provided by the HMO to enrollees in previous months; and (x) All other reports as specified and defined in the Managed Care Provider Manual/Operational Protocol and contract.

(b) The HMO will keep and make available to Medicaid, HHS, the Comptroller General, and their agents or authorized representatives, any of the HMO's records which are necessary to fully disclose and substantiate the nature, quality, cost, and extent of items and services provided to enrollees. The HMO shall maintain financial records, supporting documents, statistical records, and all other records, pertinent to the Alabama Medicaid Program for a period of five (5) years from the date of the last payment made by Medicaid to the HMO under this contract. However, when audit, litigation, or other action involving records is initiated prior to the end of the five (5) years period, records shall be maintained for a period of five (5) years following the completion of such action and the resolution of all actions which arise from it. Plans shall fully complete and submit to Medicaid quarterly financial statements. Quarterly reports are due for periods ending March 31, June 30, September 30, and December 31 and must be submitted within 45 days of the end of the reporting periods or the HMO shall pay a penalty of $100.00 for each day the financial report is delinquent. In addition, the National

Association of Insurance Commissioner's Annual Statement Blank, must be fully completed by Contractor annually and submitted to Medicaid. The HMO's annual report must be submitted no later than March 1 or Contractor shall pay to Medicaid a penalty of $100.00 for each day the annual report is delinquent. However, the Commissioner of Medicaid shall have the option to waive the penalty with shown proof by the HMO of good cause for the delay. In addition, the HMO must submit an audited financial statement to Medicaid covering the fiscal year within ninety (90) days of the end of its fiscal year. Contractor shall also promptly submit any and all other financial information requested by Medicaid, HHS, or the Comptroller General.

(14) Payment

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

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

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

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

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

(15) Compliance Review Committee

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

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

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

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

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

1. Seriousness of the offense(s)

2. Extent of violations and history of prior violations

3. Prior imposition of sanctions

4. Actions taken or recommended by Peer Review Organizations or licensing board

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

(16) Children's Health Insurance Program (CHIP). Children eligible as CHIP children, aged up to 19, who reside in counties in which HMO coverage is available may be included in the program.
Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Social Security Act, Title XIX, Section 1903(m)(2)(A)(v); 42 C.F.R. Section 434.25, Section 434.27(a)(2), §§434.28, 434.63; 42 C.F.R. Section 405.2023. OBRA 1990, Section 4122 HB, Section 615738.

History: Amended: October 1, 1991; April 15, 1992. **Amended:** Filed April 6, 1994; effective May 13, 1994. **Amended:** Filed August 12, 1994; effective September 17, 1994. **Amended:** Filed July 6, 1995; effective August 12, 1995. **Repealed and Replaced:** Filed June 6, 1996; effective July 12, 1996. **Amended:** Filed December 8, 1997; effective January 12, 1998. **Amended:** Filed May 12, 2003; effective June 16, 2003.

560-X-37-.05 Medicare Health Maintenance Organizations (MHMOs) And Competitive Medical Plans (CMPs).

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

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

(2) The Alabama Medicaid Agency may reimburse a fixed per member per month (PMPM) capitated payment established by Medicaid to HMOs and CMPs which have an approved Medicare risk contract with the Health Care Financing Administration for beneficiaries who enroll in a Medicare HMO or CMP for which Medicaid is responsible for payment of medical cost sharing. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. This PMPM payment will cover, in full, any premiums or

cost sharing required from the Medicare Plan. The PMPM payment will be established based on historical costs and negotiations.

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

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

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

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

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

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

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

Author:
Statutory Authority: Social Security Act, Title XIX, Section 1903(m)(2)(A)(vi); 42 C.F.R. Section 434.27, Section 434.63.
History: Amended: May 15, 1991, April 15, 1992. **Amended:** Filed April 6, 1994; effective May 13, 1994. **Amended:** Filed August 12, 1994; effective September 17, 1994. **Amended:** Filed July 6, 1995; effective August 12, 1995. **Repealed and Replaced:** Filed June 6, 1996; effective July 12, 1996.

560-X-37-.06 Family Planning Waiver.

(Repealed - Moved to 560-X-14-.06)
Author: Kim Davis-Allen, Director, Medical Services Division
Statutory Authority: Section 1115(a); Sections 1902(a)(10)(b), (e)(5) and (6) of the Social Security Act.

History: New Emergency Rule: Filed August 28, 2000; effective October 1, 2000. **New Rule:** Filed September 21, 2000; effective December 11, 2000. **Amended:** Filed November 8, 2001; effective December 13, 2001. **Repealed (Moved to 560-X-14-.06):** Filed December 11, 2009; effective January 15, 2010.

560-X-37-.07 Alabama Coordinated Health Network Program.

The Alabama Medicaid Agency is responsible for the development and oversight of the Alabama Coordinated Health Network (ACHN) program which provides case management programs in order to provide seamless care coordination that focuses on quality and improved health outcomes.

The ACHN program operates in seven regions. The following designations of geographic boundaries have been established for ACHN locations:

1. Central, which includes the following counties: Autauga, Butler, Chilton, Crenshaw, Dallas, Elmore, Lowndes, Marengo, Montgomery, Perry, and Wilcox.

2. East, which includes the following counties: Blount, Calhoun, Cherokee, Clay, Cleburne, Coosa, DeKalb, Etowah, Randolph, St. Clair, Talladega, and Tallapoosa.

3. Jefferson and Shelby, which includes the following counties: Jefferson and Shelby.

4. Northeast, which includes the following counties: Cullman, Jackson, Limestone, Madison, Marshall, and Morgan.

5. Northwest, which includes the following counties: Bibb, Colbert, Fayette, Franklin, Greene, Hale, Lamar, Lauderdale, Lawrence, Marion, Pickens, Sumter, Tuscaloosa, Walker, and Winston.

6. Southeast, which includes the following counties: Barbour, Bullock, Chambers, Coffee, Covington, Dale, Geneva, Henry, Houston, Lee, Macon, Pike, and Russell.

7. Southwest, which includes the following counties: Baldwin, Choctaw, Conecuh, Clarke, Escambia, Mobile, Monroe, and Washington.

Author: Keisha Hawkins, Unit Manager, Network Provider Assistance Division, Managed Care Operations
Statutory Authority: State Plan; Title XIX, Social Security Act; C.F.R. Part 438; C.F.R. §438.700 et. seq.
History: **New Rule:** Filed August 13, 2003; effective September 17, 2003. **Repealed and New Rule:** Filed July 11, 2019; effective

August 25, 2019. **Amended:** Published March 31, 2025; effective May 15, 2025.

560-X-37-.08 Sanctions Under The Alabama Coordinated Health Network Program.

(1) Bases for Imposition of Sanctions on Alabama Coordinated Health Network Entity. The Medicaid Agency may impose sanctions on an Alabama Coordinated Health Network Entity ("Entity") if the Medicaid Agency determines in its sole discretion that the Entity has violated any applicable federal or state law or regulation, the Alabama Medicaid State Plan, the contract between the Medicaid Agency and the Entity and the exhibits thereto (the "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 contract, including but not limited to a determination by the Medicaid Agency that an Entity acts or fails to act as follows:

(a) Acts to discriminate among recipients 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);

(b) Misrepresents or falsifies information that it furnishes to Agency or to CMS;

(c) Misrepresents or falsifies information that it furnishes to a recipient, Potential recipient, or health care Provider;

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

(e) Fails to submit a Corrective Action Plan (CAP) that is acceptable to the Agency within the time period specified by the Agency's written notice or does not implement or complete the corrective action within the established time period;

(f) Violates, as determined by the Agency, any requirement of sections 1932 or 1905(t) of the Social Security Act or any implementing regulations; or

(g) Violates, as determined by the Agency, any applicable requirement of the Alabama Code or the Alabama Medicaid Administrative Code.

(h) Unauthorized use of information.

(i) Failure to safeguard confidential information of Providers, recipients or the Medicaid program.

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

(a) requiring the Entity 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) grant enrollees the right to disenroll without cause (the Medicaid Agency may notify the affected Enrollees of their right to disenroll);

(d) suspend all new enrollment, including auto-assignment, after the date Department of Health and Human Services or the Medicaid Agency notifies the Entity of a determination of a violation of any requirement under Sections 1932 or 1905(t) of the Social Security Act;

(e) suspend payment for enrollees enrolled after the effective date of the sanction until CMS or the Medicaid Agency is satisfied that the reason for the imposition of the sanction no longer exists and is not likely to recur;

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

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

(h) termination of the contract, in accordance with the terms therein; and

Contract Section	Performance Standard	Intermediate Sanction

Section III. 12.1.d. and Section III.8.C. 2.b.	• Distribution of unapproved marketing material or those that contain false or materially misleading information.	• Up to $25,000 for each determination
Section III. 12.1.h.	• Unauthorized use of information	• Up to $25,000 for each determination
Section III. 12.1.i.	• Failure to safeguard confidential information of Providers, recipients or the Medicaid program.	• Up to $25,000 for each determination
Section III. 12.1.b.	• Misrepresents or falsifies information furnished to the Agency or CMS.	• Up to $100,000 for each determination.
Section III. 12.1.e. and Section III. 12.2.a.	• Failure to submit an acceptable CAP	• Up to $1,000 per instance
Section III. 12.1.e.	• Failure to comply with the Agency approved CAP	• Up to $1,000 per instance

(i) any other sanction reasonably designed to remedy noncompliance and/or compel future compliance with the contract or federal or state law or regulation, pursuant to the Medicaid Agency's authority under 42 C.F.R. §438.702(b), including, but not limited to:

Contract Section	**Performance Standard**	**Intermediate Sanction**
Section II.6.B.1. and Section III. 10.B.	• Failure to deliver quarterly reports as defined by the RFP by the date specified	• Up to $100 per day for each day delinquent per report or review
Section III.B.1.d. and Section III.B. 1.b.	• Failure to provide reports as required by	• Up to $100 per day for each day delinquent

	the RFP regarding PCP and MCP participation	
Section III.5.B.2.	• Failure to input Maternity Data for each recipient with a 95% accuracy rate into the Health Information System/Database	• Up to $100 per instance
Section III.7.A., Section III.5.B. and Section III.6.	• Failure to meet technical requirements	• Up to $1,000 per instance
Section III.5.B.2.	• Insufficient or absence of Care Coordination documentation	• Up to $500 per instance
Section III.12.1.a. and Section II.1.D. 7.a.	• Discriminate based on health status or need for health care services	• Up to $25,000 per instance
Section III.5.B.2.	• Failure to input Care Coordination documentation for each recipient with a 95% accuracy rate into the Health Information System/Database	• Up to $100 per instance
Section III.7.B.	• Noncompliance with requirements for the recipient services telephone line	• Up to $500 per instance

(3) Notice of Sanction. Before the Medicaid Agency imposes a sanction under this rule, it will give the affected Entity timely written notice explaining:

(a) the basis and nature of the sanction; and

(b) if applicable, the organization’s right to request a fair hearing.

(4) 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 monetary penalty according to this rule, the amount of the sanction imposed will be reduced by thirty five percent (35%) if the Entity 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 this rule and not to any other outstanding sanctions imposed on the Entity by the Medicaid Agency.

(5) An Entity that has been sanctioned by the Medicaid Agency may request a fair hearing:

(a) An Entity's request for a fair hearing with the Medicaid Agency relating to the imposition of a sanction must be in writing and must be filed with the Medicaid Agency within thirty (30) calendar days of the date of the sanction notice. The written request shall include a statement of the factual and/or legal basis for the Entity'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 Entity 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.

(b) Upon filing a written request for a fair hearing, the Entity may also request an informal conference with the Medicaid Agency to seek a resolution of the sanctioned activity.

(c) If mutually acceptable resolution is not reached through informal conference with the Medicaid Agency, the fair hearing shall be conducted before an impartial hearing officer in accordance with the requirements for contested case proceedings under the Alabama Administrative Procedure Act, Section 41-22-1 et seq. of the Code of Ala. 1975. The hearing authority for all fair hearings of Entity sanctions 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 Entity grievance. The hearing officer shall not have been involved in any way with the Entity sanction in question.

(d) 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 Entity's address of record and may also be communicated by email or facsimile transmission by the Director, Hearings of the Medicaid Agency,

or the designated hearing officer, at least ten (10) calendar days before the hearing is to be held. The notice shall comply with the requirements of Section 41-22-12(b) of the Code of Ala. 1975.

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

(f) 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.

(g) All fair hearings shall be conducted in accordance with the provisions of Sections 41-22-12 through 41-22-19 of the Code of Ala. 1975, unless otherwise noted in this rule. Within thirty (30) calendar days of the conclusion of the hearing, the findings and recommendations of the hearing officer shall be submitted to the Commissioner of the Medicaid Agency, who shall make a final decision within thirty (30) calendar days of the recommendation. The Medicaid Agency shall promptly send a copy of the final decision to the Entity's address of record by certified mail.

(h) The Entity may seek judicial review of the final decision of the Medicaid Agency in accordance with the provisions of Sections 41-22-20 and 41-22-21 of the Code of Ala. 1975.

(i) 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.

(6) Pre-termination Hearing. Before terminating the contract as a sanction under this rule and 42 C.F.R. §438.708, the Medicaid Agency will provide the Entity with a pre-termination hearing to be conducted in accordance with the procedures for fair hearings set forth herein. Prior to such pre-termination hearing, the Medicaid Agency will, in accordance with 42 C.F.R. §438.710:

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

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

(c) For a decision affirming the determination to terminate the contract, give enrollees of the Entity 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) 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 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 Entity. 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 Entity and/or any other person or entity for breach of contract or any other cause of action.
Author: Catrice Williams, Director, Networks Division
Statutory Authority: State Plan; Title XIX, Social Security et seq.Act; 42 C.F.R. Part 438; 42 C.F.R. §438.700
History: New Rule: Filed July 12, 2019; effective August 26, 2019. **Amended:** Published November 30, 2020; effective January 14, 2021. **Amended:** Published April 30, 2025; effective June 14, 2025.

560-X-37-.09 Attribution Under The Alabama Coordinated Health Network Program.

(1) Under the Alabama Coordinated Health Network (ACHN) Program, Medicaid recipients will be attributed to Primary Care Physician (PCP) Groups based on the historical visitation practices of the Medicaid recipient. Attribution is the process that will be used to associate a Medicaid recipient to the PCP Group that provides primary care to that recipient. Under the ACHN Program, PCP Groups will be eligible to receive bonus payments based on having a completed ACHN PCP Group Agreement with the Medicaid Agency, a PCP Network Participation Agreement with an ACHN, and meeting participation requirements as identified in the Participation Agreement; in addition to meeting quality measures, cost effectiveness measures, and Patient Centered Medical Home Recognition. If a PCP Group is eligible to receive bonus payments, the amount of the bonus payments payable to a PCP Group will be determined by the number of recipients attributed to the PCP Group. On a quarterly basis, the Medicaid Agency will perform attribution for each Medicaid recipient under the ACHN Program in accordance to the following process:

(a) The Medicaid Agency will review the previous two (2) year history of doctor visit utilization for each Medicaid recipient. Utilization will consist of preventive visits and regular office visits. A PCP is defined, by specialty, as

Family Practice, Pediatricians, Internists, General Practitioners, FQHCs, RHCs, and Nurse Practitioners / Physicians Assistants in a PCP Group. When in the best interest of a patient (e.g., children with special health care needs), a nontraditional PCP specialty may consider as a PCP. Physicians with other specialties may be considered for PCP participation if willing to meet active participation requirements. All other providers are deemed specialists.

(b) Points will only be awarded for claims that are in a paid status before the end of the attribution run period.

(c) The Medicaid Agency will review the previous twelve (12) month history of filled prescriptions for chronic care conditions for each Medicaid recipient.

(d) The point values described below associated with the visits and prescriptions will be assigned to the individual doctor that performed the service. The individual PCP scores will be combined to form the PCP Group's total point score.

(e) PCP Groups will receive points based on the number of preventive visits and regular office visits conducted by the PCP Group. Preventive visits will receive a higher point value. Visits that have occurred more recently will receive a higher point value. Visits with a PCP will receive a higher point value than visits with a specialist.

(f) PCP Groups will receive points based on the number of prescriptions filled for chronic care conditions. For the purposes of this rule, prescriptions for chronic care conditions shall mean more than one prescription filled for a chronic condition (e.g., asthma) and must correspond to an office visit from the prescribing provider within the previous two (2) years.

(g) The PCP Group with the highest number of points will have the Medicaid recipient attributed to that PCP Group. The Medicaid recipient must have been eligible for the ACHN program for three (3) out of the previous twenty-four (24) months to be attributed.

(h) If a specialist group has the highest number of points, then the specialist group will be attributed the Medicaid recipient; however, a specialist group shall not be eligible to receive the bonus payments described above.

(2) A PCP Group may request the attribution calculation for any Medicaid recipient the PCP Group has provided primary care services for in the preceding two-year period. If a PCP Group believes the Medicaid Agency has not properly attributed one or more Medicaid recipients to the PCP Group, it may request the Medicaid Agency reconsider its attribution calculation.

(a) A request for reconsideration must be submitted to the Medicaid Agency in writing and within seven (7) business days of the quarterly attribution notification. The written request for reconsideration must contain the period of attribution, the Medicaid recipient(s) the PCP Group believes was/were not properly attributed, and supporting information and/or documentation demonstrating that the Medicaid Agency either failed to or improperly considered information which had a material impact on the result of the attribution.

(b) The PCP Group that has been attributed the Medicaid recipient(s) subject to the request for reconsideration shall be notified by the Medicaid Agency of the request and be permitted to submit information for Medicaid Agency consideration within three (3) business days of the notice.

(c) The Medicaid Agency will review all relevant information and complete any adjustments to the PCP Group's Medicaid recipient attribution within seven (7) business days of receipt of the request for reconsideration.

Author: Travis D. Houser, Director, Managed Care Operations Division

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Part 438.

History: New Rule: Filed August 28, 2019; effective October 12, 2019. **Amended:** Published December 31, 2019; effective February 14, 2020. **Amended:** Published April 30, 2020; effective June 14, 2020. **Amended:** Published November 30, 2022; effective January 14, 2023.

560-X-37-.10 Payments To Primary Care Physicians And Maternity Care Providers Participating With The Alabama Coordinated Health Network.

(1) Primary Care Physician (PCP) Groups.

(a) To participate with an Alabama Coordinated Health Network (ACHN), a PCP Group must engage with the ACHN as follows:

1. PCP Groups must sign two agreements beyond their Medicaid enrollment:

(i) A PCP Group Agreement with Alabama Medicaid; and

(ii) One agreement with an ACHN entity.

2. Over a twelve (12) month period, attend in person or virtually at least three (3) quarterly Medical Management Meetings with the ACHN's Medical Director. Attendance requirements can be met by having one PCP or Nurse Practitioner/Physician Assistant from the group attend;

3. Engage in ACHN initiatives centered around quality measures;

4. Review data provided by the ACHN to help achieve Alabama Medicaid and ACHN quality goals; and

5. Engage, as appropriate, in the ACHN's Multidisciplinary Care Team and the development of an individualized and comprehensive care plan.

(b) Participation requirements will be monitored on a monthly basis by the ACHNs and Alabama Medicaid. If an ACHN indicates a PCP group is not attending meetings or engaging as described above with the ACHN, Alabama Medicaid and the ACHN will make the determination to end the PCP's Group Agreement to participate in the ACHN Program.

(c) PCP groups who participate with an ACHN will be eligible for the following payments:

1. ACHN Participation Rate: PCP Groups are eligible to earn higher payments for 13 Evaluation and Management codes if they participate with the ACHNs. For a list of these E&M codes, see State Plan Attachment 4.19-B, page 2c.1. Rates are published on the Agency's website at www.medicaid.alabama.gov. The following provider groups are not eligible to receive ACHN Participation Rates: Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), OB/GYNs and nurse midwives, and nursing facilities.

2. Performance Bonus Payments: A performance payment pool has been established in an amount determined by the Medicaid Agency to fund three (3) performance payments for participating PCP groups. The performance payments pool is allotted as follows: 50% for quality, 45% for cost effectiveness, and 5% for Patient Centered Medical Home (PCMH) Recognition. This bonus pool includes payments to FQHCs and RHCs.

3. Quality Performance Bonus Payments: All Participating PCP groups that meet or exceed annual quality benchmarks determined by Alabama Medicaid are eligible to receive a quarterly quality performance bonus payment.

(i) Quality payments for the period between October 1, 2024, and March 31, 2026, will be distributed to each PCP group based on the number of Medicaid recipients attributed to the PCP group, as determined in accordance with Rule 560-X-37-.09, for the prior quarterly period.

(ii) The Agency's quarterly payments beginning with the April 2026 payment will be based on actual quality measure performance calculated for the services rendered for the previous 12 months with a 9-month time lag on a rolling basis. For example, the quarterly payments made during April 2026, will be based on the actual quality measure performance calculated for the period between July 1, 2024, and June 30, 2025. Similarly, the quality measure payments made during July 2026, will be based on the quality measure performance calculated for the period between October 1, 2024, and September 30, 2025.

4. Cost Effectiveness Performance Payments: All Participating PCP groups that meet or exceed cost effectiveness criteria established by the Agency are eligible to receive a quality cost effectiveness bonus payment.

(i) Quarterly cost effectiveness payments will be based on actual performance. The cost effectiveness performance calculation compares a 12-month per member per month (PMPM) to a risk-adjusted expected PMPM based on the costs of similar PCP groups that treat Medicaid recipients. Groups will be ranked by an efficiency score that is derived from actual PMPM versus the expected PMPM. All Participating PCP groups that meet a cost effectiveness score of less than 1.0000 are eligible to receive a cost effectiveness bonus payment. The cost effectiveness score calculation methodology is outlined in Chapter 40 of the Provider Billing Manual on the Alabama Medicaid website. This calculation will occur as soon as the previous calendar year's performance has been calculated. These payments will be distributed to each PCP group based on the number of Medicaid recipients attributed to the PCP group, as determined in accordance with Rule 560-X-37-.09, for the prior quarterly period.

5. PCMH Recognition Performance Payments: The purpose of the PCMH Recognition performance payment is to incentivize providers to attain PCMH Recognition thereby ensuring Medicaid recipients are receiving care through a nationally recognized medical home model. All PCP groups who receive PCMH recognition will receive a quarterly bonus payment. The PCP group can obtain PCMH Recognition or certification through a nationally recognized entity such as National Committee for Quality Assurance (NCQA).

(i) Payments made for the period between October 1, 2019, and September 30, 2020, will be made based on the number of Medicaid Recipients attributed to the

PCP group, as determined in accordance with Rule 560-X-37-.09, for the prior quarterly period.

(ii) Payments made after October 1, 2020, will be based on the PCP groups attestation of PCMH Recognition. The amount of the bonus payment will be distributed based on the number of Medicaid Recipients attributed to the PCP group, as determined in accordance with Rule 560-X-37-.09, for the prior quarterly period. Beginning October 1, 2020, if a PCP group does not meet PCMH Recognition, the Agency will not pay the PCMH bonus payment to the PCP group.

(2) Maternity Care Providers (MCPs)

(a) To participate with an ACHN, a MCP group must engage with an ACHN as follows:

1. A MCP must sign a Maternity Care Provider Group Agreement with an ACHN;

2. Provide data to the ACHN;

3. Engage in the development of the Medicaid recipient's care plan; and

4. Engage in the MCP selection and referral process.

(b) Participation requirements will be monitored on a monthly basis by ACHNs and Alabama Medicaid. If the ACHN indicates a MCP group is not providing data to the ACHNs, engaging in the development of the care plan, or engaging in the selection and referral process, Alabama Medicaid and the ACHN will make the determination to end the MCP's contract. MCPs who fail to meet these requirements will neither be referred Medicaid recipients by the ACHN nor will be able to provide maternity services to the ACHN population.

(c) MCPs participating with the ACHN are eligible to receive a bonus payment for providing the following services:

1. an initial prenatal visit in the first trimester and/ or

2. post-partum visits.

Author: Keisha Hawkins, Unit Manager, Network Provider Assistance Division, Managed Care Operations
Statutory Authority: Social Security Act, Title XIX, State Plan, Attachment 4.19-B.
History: New Rule: Published February 28, 2020; effective April 13, 2020. **Amended:** Published September 30, 2021; effective November 14, 2021. **Amended:** Published November 30, 2022;

effective January 14, 2023. **Amended:** Published March 31, 2025; effective May 15, 2025.