Rule No. 560-X-62-.11 Provider Contract Disputes – NEW RULE

(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.

(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.

(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.

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