205.532 Definitions for KRS 205.532 to 205.536 -- Contracts for Medicaid services by managed care organizations -- Credentialing alliance -- Procedures -- Enrollment of and contracts with providers -- Failure to agree on terms and conditions -- Application date -- Credentialing verification by university hospitals -- Electronic verification of licensure information.

(1) As used in KRS 205.532 to 205.536:

(a) "Clean application" means:

1. For credentialing purposes, a credentialing application submitted by a provider to a credentialing verification organization that:

a. Is complete and correct;

b. Does not lack any required substantiating documentation; and

c. Is consistent with the requirements for the National Committee for Quality Assurance requirements; or

2. For enrollment purposes, an enrollment application submitted by a provider to the department that:

a. Is complete and correct;

b. Does not lack any required substantiating documentation;

c. Complies with all provider screening requirements pursuant to 42 C.F.R. pt. 455; and

d. Is on behalf of a provider who does not have accounts receivable with the department;

(b) "Credentialing alliance" means a contractual agreement entered into by Medicaid managed care organizations under which the managed care organizations agree to utilize a single credentialing verification organization and an identical credentialing process for the purpose of ensuring the timely and efficient credentialing of providers;

(c) "Credentialing application date" means the date that a credentialing verification organization receives a clean application from a provider;

(d) "Credentialing verification organization" means an organization that gathers data and verifies the credentials of providers in a manner consistent with federal and state laws and the requirements of the National Committee for Quality Assurance;

(e) "Department" means the Department for Medicaid Services;

(f) "Medicaid managed care organization" or "managed care organization" means an entity with which the department has contracted to serve as a managed care organization as defined in 42 C.F.R. sec. 438.2;

(g) "Provider" has the same meaning as in KRS 304.17A-700; and

(h) "Request for proposals" has the same meaning as in KRS 45A.070.

(2) Every contract entered into or renewed on or after June 29, 2023, for the delivery of Medicaid services by a managed care organization shall:

(a) Be in compliance with KRS 205.522 and 205.532 to 205.536; and

(b) Require participation in a credentialing alliance recognized by the department

pursuant to subsection (4) of this section if such an alliance has been established or utilization of the credentialing organization designated by the department pursuant to subsection (5) of this section.

(3) The department shall enroll a provider within sixty (60) calendar days of receipt of a clean provider enrollment application. The date of enrollment shall be the date that the provider's clean application was initially received by the department. The time limits established in this section shall be tolled or paused for any delay caused by an external entity. Tolling events include but are not limited to the screening requirements contained in 42 C.F.R. pt. 455 and searches of federal databases maintained by entities such as the United States Centers for Medicare and Medicaid Services.

(4) (a) The department shall formally recognize a credentialing alliance formed by managed care organizations if:

1. One hundred percent (100%) of the total number of managed care organizations have entered into a contractual agreement to form the credentialing alliance prior to December 1, 2023;
2. The credentialing verification organization contracted as part of the credentialing alliance is accredited by the National Committee for Quality Assurance; and
3. The credentialing verification organization contracted as part of the credentialing organization is owned by or affiliated with a statewide healthcare trade association.

(b) A credentialing alliance established pursuant to this section shall:

1. Implement a single credentialing application via a web-based portal available to all providers seeking to be credentialed for any Medicaid managed care organization that participates in the credentialing alliance;
2. Perform primary source verification and credentialing committee review of each credentialing application that results in a recommendation on the provider's credentialing within thirty (30) days of receipt of a clean application;
3. Notify providers within five (5) business days of receipt of a credentialing application if the application is incomplete;
4. Provide provider outreach and help desk services during common business hours to facilitate provider applications and credentialing information;
5. Expeditiously communicate the credentialing recommendation and supporting credentialing information electronically to the department and to each participating Medicaid managed care organization with which the provider is seeking credentialing; and
6. Conduct reevaluation of provider documentation when required pursuant to state or federal law or when necessary for the provider to maintain participation status with a Medicaid managed care organization.

(5) (a) If a credentialing alliance has not been established and recognized by the

department pursuant to subsection (4) of this section by December 31, 2023, the department shall, through a request for proposals and in accordance with KRS Chapter 45A, designate a single credentialing verification organization to verify the credentials of providers on behalf of all managed care organizations.

(b) If the department designates a single credentialing verification organization pursuant to this subsection:

1. The contract between the department and the credentialing verification organization shall be submitted to the Government Contract Review Committee of the Legislative Research Commission for comment and review;
2. The credentialing verification organization shall be reimbursed on a per provider credentialing basis by the department with the reimbursement being offset or deducted equally from each managed care organizations capitation payment;
3. The credentialing verification organization shall comply with paragraph (b) of subsection (4) of this section; and
4. The department may promulgate administrative regulations in accordance with KRS Chapter 13A to ensure the timely and efficient credentialing of providers.

(6) If a Medicaid managed care organization assumes responsibility and costs for their own provider credentialing by entering into a credentialing alliance pursuant to this section, the timely credentialing of providers shall be given significant weight as a factor in the scoring process when the department evaluates the Medicaid managed care organization's response to requests for proposals for all contract awards.

(7) A Medicaid managed care organization shall:

(a) Determine whether it will contract with the provider within thirty (30) calendar days of receipt of the verified credentialing information from a credentialing verification organization either designated by the department or contracted by managed care organizations as part of a credentialing alliance; and

(b) 1. Within ten (10) days of an executed contract, ensure that any internal processing systems of the managed care organization have been updated to include:

a. The accepted provider contract; and
b. The provider as a participating provider.

2. In the event that the loading and configuration of a contract with a provider will take longer than ten (10) days, the managed care organization may take an additional fifteen (15) days if it has notified the provider of the need for additional time.

(8) (a) Nothing in this section requires a Medicaid managed care organization to contract with a provider if the managed care organization and the provider do not agree on the terms and conditions for participation.

(b) Nothing in this section shall prohibit a provider and a managed care organization from negotiating the terms of a contract prior to the completion of the department's enrollment and screening process.

(9) (a) For the purpose of reimbursement of claims, once a provider has met the terms and conditions for credentialing and enrollment, the provider's credentialing application date shall be the date from which the provider's claims become eligible for payment.

(b) A Medicaid managed care organization shall not require a provider to appeal or resubmit any clean claim submitted during the time period between the provider's credentialing application date and the completion of the credentialing process.

(c) Nothing in this section shall limit the department's authority to establish criteria that allow a provider's claims to become eligible for payment in the event of lifesaving or life-preserving medical treatment, such as, for an illustrative but not exclusive example, an organ transplant.

(10) Nothing in this section shall prohibit a university hospital, as defined in KRS 205.639, from performing the activities of a credentialing verification organization for its employed physicians, residents, and mid-level practitioners where such activities are delineated in the hospital's contract with a Medicaid managed care organization. The provisions of subsections (3), (4), (8), and (9) of this section with regard to payment and timely action on a credentialing application shall apply to a credentialing application that has been verified through a university hospital pursuant to this subsection.

(11) To promote seamless integration of licensure information, the relevant provider licensing boards in Kentucky are encouraged to forward and provide licensure information electronically to the department and any credentialing verification organization.

Effective: June 29, 2023

History: Amended 2023 Ky. Acts ch. 130, sec. 2, effective June 29, 2023. -- Amended 2021 Ky. Acts ch. 97, sec. 1, effective June 29, 2021. -- Amended 2019 Ky. Acts ch. 27, sec. 1, effective June 27, 2019. -- Created 2018 Ky. Acts ch. 106, sec. 1, effective January 1, 2019.

Legislative Research Commission Note (6/29/2023). 2023 Ky. Acts ch. 130, sec. 3, provides that in implementing the requirements of this statute, the state shall only regulate a pharmacy benefit manager or an insurer to the extent permissible under applicable law.

Legislative Research Commission Note (6/29/2023). Under the authority of KRS 7.136(1), the Reviser of Statutes has changed the ordering of paragraphs in subsection (1) of this statute to place the defined terms in alphabetical order. The words in the statute were not changed.

Legislative Research Commission Note (1/1/2019). As enacted in 2018 Ky. Acts ch. 106, sec. 1, subsection (2) of this statute contains the phrase "the effective date of this Act." The phrase is ambiguous, since the Act has two effective dates: some sections are effective on January 1, 2019, and some are effective on July 14, 2018. In codifying this statute, the Reviser of Statutes has chosen January 1, 2019, as the proper date to be substituted for the phrase "the effective date of this Act" in this subsection, since the effective date of KRS 205.532 is January 1, 2019. See KRS

7.136(1).