

**CHAPTER 106****( HB 69 )**

AN ACT relating to service delivery improvements in managed care networks.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

(1) *As used in Sections 1 to 5 of this Act:*

(a) *"Clean application" means a credentialing application submitted by a provider to a credentialing verification organization that:*

1. *Is complete; and*
2. *Does not lack any required substantiating documentation;*

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

(c) *"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. "Credentialing verification organization" is limited to the following:*

1. *An organization designated by the department pursuant to subsection (3)(a) of this section; and*
2. *Any bona fide, nonprofit, statewide, health care provider trade association, organized under the laws of Kentucky, that has an existing contract with the department or a managed care organization, as of July 1, 2018, to perform credentialing verification activities for its members, providers who are employed by its members, or providers who practice at the members' facilities;*

(d) *"Department" means the Department for Medicaid Services;*

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

(f) *"Provider" has the same meaning as in Section 9 of this Act; and*

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

(2) *On and after the effective date of this Act, every contract entered into or renewed for the delivery of Medicaid services by a managed care organization shall be in compliance with Sections 1 to 5, 6, and 7 of this Act.*

(3) (a) *Through a request for proposals, the department shall designate a single organization as a credentialing verification organization to verify the credentials of providers on behalf of the department and all managed care organizations.*

(b) *Following the department's designation pursuant to this subsection, the contract between the department and the designated credentialing verification organization shall be submitted to the Government Contract Review Committee of the Legislative Research Commission for comment and review.*

(c) *A credentialing verification organization shall be reimbursed on a per provider credentialing basis by the department. This expense shall be reduced from Medicaid managed care organizations capitation rates.*

(d) *Each provider seeking to be enrolled in Medicaid and credentialed with the department and a Medicaid managed care organization shall submit a single credentialing application to the designated credentialing verification organization, or to an organization meeting the requirements of subsection (1)(c)2., if applicable. The credentialing verification organization shall:*

1. *Gather all necessary documentation from each provider;*

2. *Within five (5) days of receipt of a credentialing application, notify the provider in writing if the application is complete;*
  3. *Review an application for any misstatement of fact or lack of substantiating documentation;*
  4. *Provide verified credentialing packets to the department and to each managed care organization as requested by the provider within thirty (30) calendar days of receipt of a clean application; and*
  5. *Conduct reevaluations of provider documentation when required by state or federal law or for the provider to maintain participation status with the department or a managed care organization.*
- (4) (a) *The department shall enroll a provider within thirty (30) calendar days of receipt of a verified credentialing packet for the provider from a credentialing verification organization. The date of enrollment shall be the date that the provider's clean application was initially received by a credentialing verification organization.*
- (b) *A Medicaid managed care organization shall:*
1. *Determine whether it will contract with the provider within thirty (30) calendar days of receipt of the verified credentialing packet from the credentialing verification organization; and*
  2. a. *Within ten (10) days of an executed contract, ensure that any internal processing systems of the managed care organization has been updated to include:*
    - i. *The accepted provider contract; and*
    - ii. *The provider as a participating provider.*
  - b. *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.*
- (5) *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.*
- (6) (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 a managed care organization's completion of its credentialing process.*
- (7) *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), (5), and (6) 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.*

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

*By January 1, 2019, a managed care organization shall establish an interactive Web site, operated by the managed care organization, that allows providers to file grievances, appeals, and supporting documentation electronically in an encrypted format that complies with federal law and that allows a provider to review the current status of a matter relating to an appeal or a grievance filed concerning a submitted claim.*

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

- (1) *A Medicaid managed care organization shall:*
- (a) *Provide:*
1. *A toll-free telephone line for providers to contact the insurer for claims resolution for forty (40) hours a week during normal business hours in this state;*

2. *A toll-free telephone line for providers to submit requests for authorizations of covered services during normal business hours and extended hours in this state on Monday and Friday through 6 p.m., including federal holidays;*
  3. *With regards to any adverse payment or coverage determination, copies of all documents, records, and other information relevant to a determination, including medical necessity criteria and any processes, strategies, or evidentiary standards relied upon, if requested by the provider. Documents, records, and other information required to be provided under this paragraph shall be provided at no cost to the provider; and*
  4. *For any adverse payment or coverage determination, a written reply in sufficient detail to inform the provider of all reasons for the determination. The written reply shall include information about the provider's right to request and receive at no cost to the provider documents, records, and other information under subparagraph (a)3. of this subsection;*
- (b) *Afford each participating provider the opportunity for an in-person meeting with a representative of the managed care organization on:*
1. *Any clean claim that remains unpaid in violation of KRS 304.17A-700 to 304.17A-730; and*
  2. *Any claim that remains unpaid for forty-five (45) days or more after the date the claim is received by the managed care organization and that individually or in the aggregate exceeds two thousand five hundred dollars (\$2,500);*
- (c) *Reprocess claims that are incorrectly paid or denied in error, in compliance with KRS 304.17A-708. The reprocessing shall not require a provider to rebill or resubmit claims to obtain correct payment. No claim shall be denied for timely filing if the initial claim was timely submitted; and*
- (d) *Establish processes for internal appeals, including provisions for:*
1. *Allowing a provider to file any grievance or appeal related to the reduction or denial of the claim within sixty (60) days of receipt of a notification from the managed care organization that payment for a submitted claim has been reduced or denied; and*
  2. *Ensuring the timely consideration and disposition of any grievance or any appeal within thirty (30) days from the date the grievance or appeal is filed with the managed care organization by a provider under this paragraph.*
- (2) (a) *For the purposes of this subsection:*
1. *"Timely" means that an authorization or preauthorization request shall be approved:*
    - a. *For an expedited authorization request, within seventy-two (72) hours after receipt of the request. The timeframe for an expedited authorization request may be extended by up to fourteen (14) days if:*
      - i. *The enrollee requests an extension; or*
      - ii. *The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and*
    - b. *For a standard authorization request, within two (2) business days. The timeframe for a standard authorization request may be extended by up to fourteen (14) additional days if:*
      - i. *The provider or enrollee requests an extension; or*
      - ii. *The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and*
  2. a. *"Expedited authorization request" means a request for authorization or preauthorization where the provider determines that following the standard a timeframe could seriously jeopardize an enrollee's life or health, or ability to attain, maintain, or regain maximum function; and*
  - b. *A request for authorization or preauthorization for treatment of an enrollee with a diagnosis of substance use disorder shall be considered an expedited authorization request by the provider and the managed care organization.*

- (b) *A decision by a managed care organization on an authorization or preauthorization request for physical, behavioral, or other medically necessary services shall be made in a timely and consistent manner so that Medicaid members with comparable medical needs receive a comparable, consistent level, amount, and duration of services as supported by the member's medical condition, records, and previous affirmative coverage decisions.*
- (3) (a) *Each managed care organization shall report on a monthly basis to the department:*
1. *The number and dollar value of claims received that were denied, suspended, or approved for payment;*
  2. *The number of requests for authorization of services and the number of such requests that were approved and denied;*
  3. *The number of internal appeals and grievances filed by members and by providers and the type of service related to the grievance or appeal, the time of resolution, the number of internal appeals and grievances where the initial denial was overturned and the type of service and dollar amount associated with the overturned denials; and*
  4. *Any other information required by the department.*
- (b) *The data required in paragraph (a) of this subsection shall be separately reported by provider category, as prescribed by the department, and shall at a minimum include inpatient acute care hospital services, inpatient psychiatric hospital services, outpatient hospital services, residential behavioral health services, and outpatient behavioral health services.*
- (4) *On a monthly basis, the department shall transmit to the Department of Insurance a report of each corrective action plan, fine, or sanction assessed against a Medicaid managed care organization for violation of a Medicaid managed care organization's contract relating to prompt payment of claims. The Department of Insurance shall then make a determination of whether the contract violation was also a violation of KRS 304.17A-700 to 304.17A-733.*
- (5) *Any Medicaid managed care organization that fails to comply with this section and Sections 1 to 5, 6, and 7 of this Act may be subject to fines, penalties, and sanctions, up to and including termination, as established under its Medicaid managed care contract with the department.*

➔SECTION 4. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

*The department shall not automatically assign a Medicaid enrollee to a managed care organization.*

➔SECTION 5. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

- (1) *A Medicaid managed care organization shall have a utilization review plan, as defined in KRS 304.17A-600, that meets the requirements established in 42 C.F.R. pts. 431, 438, and 456. If the Medicaid managed care organization utilizes a private review agent, as defined in KRS 304.17A-600, the agent shall comply with all applicable requirements of KRS 304.17A-600 to 304.17A-633.*
- (2) *In conducting utilization reviews for Medicaid benefits, each Medicaid managed care organization shall use the medical necessity criteria selected by the Department of Insurance pursuant to Section 10 of this Act, for making determinations of medical necessity and clinical appropriateness pursuant to the utilization review plan required by subsection (1) of this section.*

➔Section 6. KRS 205.522 is amended to read as follows:

A managed care organization that provides Medicaid benefits pursuant to this chapter shall comply with the provisions of KRS 304.17A-235, *Section 7 of this Act*, and 304.17A-740 to 304.17A-743.

➔Section 7. KRS 304.17A-515 is amended to read as follows:

- (1) A managed care plan shall arrange for a sufficient number and type of primary care providers and specialists throughout the plan's service area to meet the needs of enrollees. Each managed care plan shall demonstrate that it offers:
  - (a) An adequate number of accessible acute care hospital services, where *physically* available;
  - (b) An adequate number of accessible primary care providers, including family practice and general practice physicians, internists, obstetricians/gynecologists, and pediatricians, where available;

- (c) An adequate number of accessible specialists and subspecialists, and when the specialist needed for a specific condition is not represented on the plan's list of participating specialists, enrollees have access to nonparticipating health care providers with prior plan approval;
- (d) The availability of specialty services; and
- (e) A provider network that meets the following accessibility requirements:
  - 1. For urban areas, a provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence or work, to the extent that services are available; or
  - 2. For areas other than urban areas, a provider network that makes available primary care physician services, hospital services, and pharmacy services within thirty (30) minutes or thirty (30) miles of each enrollee's place of residence or work, to the extent those services are available. All other providers shall be available to all persons enrolled in the plan within fifty (50) minutes or fifty (50) miles of each enrollee's place of residence or work, to the extent those services are available.
- (2) A managed care plan shall provide telephone access to the plan during business hours to ensure plan approval of nonemergency care. A managed care plan shall provide adequate information to enrollees regarding access to urgent and emergency care.
- (3) A managed care plan shall establish reasonable standards for waiting times to obtain appointments, except as provided for emergency care.

➔Section 8. KRS 304.17A-576 is amended to read as follows:

- (1) An insurer issuing a managed care plan shall notify an applicant of its determination regarding a properly submitted application for credentialing within *forty-five (45)*~~ninety (90)~~ days of receipt of an application containing all information required by the most recent version of the Council for Affordable *Quality* Healthcare (CAQH) credentialing form. Nothing in this section shall prevent an insurer from requiring information beyond that contained in the credentialing form to make a determination regarding the application.
- (2) The *forty-five (45)*~~ninety (90)~~ day requirement set forth in subsection (1) of this section shall not apply if the failure to notify is due to or results from, in whole or in part, acts or events beyond the control of the insurer issuing a managed care plan, including but not limited to acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbances, riots, or complete or partial disruptions of facilities.
- (3) Following credentialing, the applicant and, upon the applicant's signing of a contract with the managed care plan, the insurer shall make payments to the applicant for services rendered during the credentialing process in accordance with procedures for reimbursement for participating providers.
- (4) An applicant for which an application for credentialing is denied shall be reimbursed, if the enrollee is enrolled in a plan which provides for out-of-network benefits, by the insurer issuing a managed care plan in accordance with procedures for reimbursement to nonparticipating providers.

➔Section 9. KRS 304.17A-700 is amended to read as follows:

As used in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123:

- (1) "Adjudicate" means an insurer pays, contests, or denies a clean claim;
- (2) "Claims payment time frame" means the time period prescribed under KRS 304.17A-702 following receipt of a clean claim from a provider at the address published by the insurer, whether it is the address of the insurer or a delegated claims processor, within which an insurer is required to pay, contest, or deny a health care claim;
- (3) "Clean claim" means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:
  - (a) A clean claim from an institutional provider shall consist of:
    - 1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
    - 2. Entries stated as mandatory by the NUBC; and
    - 3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

- (b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.
- (c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.
- (d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;
- (4) "Commissioner" means the commissioner of the Department of Insurance;
- (5) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services;
- (6) "Department" means the Department of Insurance;
- (7) "Electronic" or "electronically" means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;
- (8) "Health benefit plan" has the same meaning as provided in KRS 304.17A-005;
- (9) "Health care provider" or "provider" means a provider licensed in Kentucky as defined in KRS 304.17A-005 and, for the purposes of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, **and Section 1 of this Act**, 304.14-135, and 304.99-123 only, shall include physical therapists licensed under KRS Chapter 327, psychologists licensed under KRS Chapter 319, and social workers licensed under KRS Chapter 335. Nothing contained in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall be construed to include physical therapists, psychologists, and social workers as a health care provider or provider under KRS 304.17A-005;
- (10) "Health claim attachments" means medical information from a covered person's medical record required by the insurer containing medical information relating to the diagnosis, the treatment, or services rendered to the covered person and as may be required pursuant to KRS 304.17A-720;
- (11) "Institutional provider" means a health care facility licensed under KRS Chapter 216B;
- (12) "Insurer" has the same meaning provided in KRS 304.17A-005;
- (13) "Kentucky Uniform Billing Committee (KUBC)" means the committee of health care providers, governmental payors, and commercial insurers established as a local arm of NUBC to implement the bill requirements of the NUBC and to prescribe any additional billing requirements unique to Kentucky insurers;
- (14) "National Uniform Billing Committee (NUBC)" means the national committee of health care providers, governmental payors, and commercial insurers that develops the national uniform billing requirements for institutional providers as referenced in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, secs. 300gg et seq.;
- (15) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person; and
- (16) "Utilization review" has the same meaning as provided in KRS 304.17A-600~~[(18)]~~.

➔SECTION 10. A NEW SECTION OF SUBTITLE 38 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

- (1) (a) *The commissioner shall promulgate an administrative regulation to establish procedures for conducting a competitive process to solicit proposals from publishers of medical necessity criteria to designate for each category of services which medical necessity criteria Medicaid managed care organizations, as defined in Section 1 of this Act, shall use to determine the medical necessity and clinical appropriateness of proposed services pursuant to the utilization review plan required by Section 5 of this Act.*
- (b) *The procedures shall require:*
  - 1. *The department to provide adequate public notice of the deadline for publishers of medical necessity criteria to submit proposals; and*
  - 2. a. *The commissioner to issue a final order at the conclusion of the competitive process.*

- b. *The order shall designate, for each category of services, one (1) set of medical necessity criteria determined by the commissioner to be the most advantageous to the Commonwealth.*
      - c. *Nothing in this section shall preclude the commissioner from designating the same set of medical necessity criteria for two (2) or more categories of service if the commissioner determines, in accordance with the procedures required by this subsection, that the designation would be the most advantageous to the Commonwealth.*
    - (c) *The procedures shall permit any person who is aggrieved in connection with the solicitation of proposals or the commissioner's final order to request a hearing pursuant to KRS 304.2-310.*
  - (2) (a) *For purposes of this subsection, "objective and evidence-based" includes:*
    - 1. *Methods or systems where:*
      - a. *The publisher evaluates and grades the sufficiency of medical evidence incorporated into the criteria;*
      - b. *The publisher reviews and updates the criteria periodically as appropriate, but no less frequently than annually; and*
      - c. *The criteria are evaluated annually by a panel of one (1) or more physicians not directly employed by the publisher of the criteria; and*
    - 2. *Sufficient unique citations to published medical research and other peer-reviewed literature to substantiate the criteria's evidentiary basis.*
  - (b) *In conducting the competitive process required by subsection (1) of this section, the commissioner shall only accept proposals from publishers of medical necessity criteria if the criteria:*
    - 1. *Are nationally recognized;*
    - 2. *Are objective and evidence-based; and*
    - 3. *Are not proprietary property of a Medicaid managed care organization or a subsidiary of a Medicaid managed care organization, or a corporation which a Medicaid managed care organization controls or owns more than five percent (5%) of the stock.*
- (3) *The categories of service shall be limited to:*
  - (a) *Physical health services;*
  - (b) *Behavioral health services; and*
  - (c) *Any other categories of service required under federal law for Medicaid managed care.*
- (4) (a) *Notwithstanding KRS 13A.3102, any administrative regulation promulgated under this section shall expire two (2) years from the last effective date, as defined in KRS 13A.010, unless the department follows the certification or amendment process established in KRS 13A.3104.*
- (b) *If the department files a certification letter pursuant to KRS 13A.3104, and does not intend to amend an administrative regulation promulgated under this section, it shall allow for a public comment period and public hearing on the certification letter meeting the requirements of KRS 13A.270.*
- (5) *In promulgating any administrative regulation under this section, the commissioner shall:*
  - (a) *Collaborate with the Department for Medicaid Services to ensure that the regulation is consistent with:*
    - 1. *Federal requirements relating to Medicaid managed care medical necessity review criteria; and*
    - 2. *Any administrative regulation promulgated by the Department for Medicaid Services that is not inconsistent with this section, relating to the processes Medicaid managed care organizations are required to follow when using the medical necessity criteria designated pursuant to this section;*
  - (b) *Set forth in any federal mandate analysis comparison for an administrative regulation promulgated under this section:*

1. *A description of any federal requirements relating to Medicaid managed care medical necessity review criteria; and*
  2. *A summary of all input provided by the Department for Medicaid Services to the commissioner relating to the form and content of the regulation; and*
- (c) *Receive from the Department for Medicaid Services the input of healthcare professionals, which shall include members of the Advisory Council for Medical Assistance established pursuant to KRS 205.540, in each category of care in accordance with subsection (3) of this section.*

➔Section 11. KRS 304.3-200 is amended to read as follows:

- (1) The commissioner may, in his or her discretion, refuse to continue or may suspend or revoke an insurer's certificate of authority if he or she finds after a hearing thereon, or upon waiver of hearing by the insurer, that the insurer has:
- (a) Willfully violated or willfully failed to comply with any lawful order of the commissioner; or
  - (b) Willfully violated or willfully failed to comply with any lawful regulation of the commissioner; or
  - (c) Willfully violated any provision of this code other than those for violation of which suspension or revocation is mandatory; or
  - (d) Failed to pay taxes on its premiums as required by law; or
  - (e) Has committed any unfair claims settlement practice as defined in Subtitle 12 or regulations promulgated thereunder.
- In lieu of or in addition to such suspension or revocation, the commissioner may, in his or her discretion, reprimand the insurer, which shall be made a part of the insurer's record, or may levy upon the insurer, and the insurer shall pay forthwith, an administrative fine as specified in KRS 304.99-020.
- (2) The commissioner shall suspend or revoke an insurer's certificate of authority on any of the following grounds, if he or she finds after a hearing thereon that the insurer:
- (a) Is in unsound condition, or is being fraudulently conducted, or is in such condition or using such methods and practices in the conduct of its business as to render its further transaction of insurance in this state currently or prospectively hazardous or injurious to policyholders or to the public;
  - (b) With such frequency as to indicate its general business practice in this state:
    1. Has without just cause failed to pay, or delayed payment of, claims arising under its policies, whether the claim is in favor of an insured or is in favor of a third person with respect to the liability of an insured to such third person; or
    2. Without just cause compels insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to secure full payment or settlement of such claims;
  - (c) Refuses to be examined, or if its directors, officers, employees or representatives refuse to submit to examination relative to its affairs, or to produce its accounts, records and files for examination by the commissioner when required, or refuse to perform any legal obligation relative to the examination;
  - (d) Has failed to pay any final judgment rendered against it in this state upon any policy, bond, recognizance or undertaking as issued or guaranteed by it, within thirty (30) days after the judgment became final or within thirty (30) days after dismissal of an appeal before final determination, whichever date is the later;
  - (e) Has actual knowledge by the chief executive officer or person in charge of Kentucky operations that an agent employed by the insurer has engaged or is engaging in conduct in violation of this code and the insurer has failed to report such conduct to the department; or
  - (f) No insurer, its agents, servants, or employees shall incur any liability in connection with or as a result of any disclosure made to the commissioner of insurance pursuant to the provisions of this section.
- (3) The commissioner may, in his or her discretion and without advance notice or a hearing thereon, immediately suspend the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation or other delinquency proceedings have been commenced in any state by the public insurance supervisory officer of such state.



- (4) *The commissioner may, in his or her discretion, refuse to continue or may suspend or revoke an insurer's certificate of authority if he or she finds after a hearing thereon, or upon waiver of hearing by the insurer, that the insurer has contracted with the Department for Medicaid Services to act as a managed care organization providing Medicaid benefits pursuant to KRS Chapter 205 and has exhibited willful or frequent and repeated failure to comply with KRS 304.17A-700 to 304.17A-730, 205.593, and 304.14-135 and Sections 1 to 5, 6, and 7 of this Act.*

➔Section 12. KRS 304.38-130 is amended to read as follows:

- (1) The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this subtitle if the commissioner finds that any of the conditions exist for which the commissioner could suspend or revoke a certificate of authority as provided in Subtitles 2 and 3 of this chapter or if the commissioner finds that any of the following conditions exist:
- (a) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under KRS 304.38-040, unless amendments to such submissions have been filed with and approved by the commissioner;
  - (b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of KRS 304.38-050 or Subtitle 17A of this chapter;
  - (c) The health maintenance organization does not provide or arrange for health care services as approved by the commissioner in KRS 304.38-050(1)(a);
  - (d) The certificate of need and licensure board certifies to the commissioner that the health maintenance organization fails to meet the requirements of the board or that the health maintenance organization is unable to fulfill its obligations to furnish health care services;
  - (e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;
  - (f) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;
  - (g) The continued operation of the health maintenance organization would be hazardous to its enrollees;~~for~~
  - (h) The health maintenance organization has otherwise failed to substantially comply with this subtitle; *or*
  - (i) *The health maintenance organization has contracted with the Department for Medicaid Services to act as a managed care organization providing Medicaid benefits pursuant to KRS Chapter 205 and has exhibited willful or frequent and repeated failure to comply with KRS 304.17A-700 to 304.17A-730, 205.593, and 304.14-135 and Sections 1 to 5, 6, and 7 of this Act.*
- (2) If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.
- (3) If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit the further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage. If the commissioner permits such further operation the health maintenance organization will continue to collect the periodic prepayments required of enrollees.

➔Section 13. KRS 304.99-123 is amended to read as follows:

- (1) In addition to any other penalty or remedy authorized by law, the department may assess the following fines for noncompliance with KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123:

- (a) A fine of one thousand dollars (\$1,000) per day or ten percent (10%) of the unpaid claim amount, whichever is greater, for each day that a clean claim remains unpaid in violation of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123; and
  - (b) Except for the late payment of claims under subsection (2) of this section, a fine of up to ten thousand dollars (\$10,000) where the commissioner determines that an insurer has willfully and knowingly violated KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 or has a pattern of repeated violations of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.
- (2) For purposes of paragraph (a) of subsection (1) of this section ***and subsection (3) of this section***, an insurer is in compliance when:
- (a) Ninety-five percent (95%) of the clean claims received by the insurer, its agent, or designee during each calendar quarter, excluding pharmaceutical claims, were adjudicated within the claims payment timeframes in accordance with KRS 304.17A-702; and
  - (b) At least ninety percent (90%) of the total dollar amount for clean claims received by the insurer, its agent, or designee during each calendar quarter, excluding pharmaceutical claims, that were not denied or contested, was paid within the claims payment timeframes established in KRS 304.17A-702.
  - (3) ***In addition to any other penalty or remedy authorized by law, the department may assess the fines authorized by subsection (1) of this section against any Medicaid managed care organization, as defined in Section 1 of this Act, for noncompliance with KRS 304.17A-700 to 304.17A-730, 205.593, and 304.14-135 and Sections 1 to 5, 6, and 7 of this Act.***

➔Section 14. Sections 1, 3, 4, 5, 6, 7, 8, and 9 of this Act take effect January 1, 2019.

**Became law without Governor's signature April 4, 2018.**