CHAPTER 130

(SB 209)

AN ACT relating to health care.

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

➔Section 1. KRS 304.17A-164 is amended to read as follows:

(1) As used in this section:

(a) "Cost sharing" means the cost to an~~[individual]~~ insured under a health plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan, which may be subject to annual limitations on cost sharing, including those imposed under 42 U.S.C. secs. 18022(c) and 300gg-6(b), in order for ***the insured***~~[an individual]~~ to receive a specific health care service covered by the plan;

(b) "Generic alternative" means a drug that is designated to be therapeutically equivalent by the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, except that a drug shall not be considered a generic alternative until the drug is nationally available;

(c) "Health plan":

1. Means a policy, contract, certificate, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the cost of health care services; and

2. Includes a health benefit plan~~[as defined in KRS 304.17A-005]~~;

(d) "Insured" means any individual who is enrolled in a health plan and on whose behalf the insurer is obligated to pay for or provide health care services;

(e) "Insurer" includes:

1. An insurer offering a health plan providing coverage for pharmacy benefits; or

2. Any other administrator of pharmacy benefits under a health plan;

(f) "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, government, or governmental subdivision or agency;

(g) "Pharmacy" includes:

1. A pharmacy, as defined in KRS Chapter 315;

2. A pharmacist, as defined in KRS Chapter 315; ***and***~~[or]~~

3. Any employee of a pharmacy or pharmacist; and

(h) "Pharmacy benefit manager" has the same meaning as in KRS 304.17A-161.

(2) To the extent permitted under federal law ***and except as provided in subsection (4) of this section***, an insurer issuing or renewing a health plan on or after January 1, 2022, or a pharmacy benefit manager, shall not:

(a) Require an insured purchasing a prescription drug to pay a cost-sharing amount greater than the amount the insured would pay for the drug if he or she were to purchase the drug without coverage;

(b) Exclude any cost-sharing amounts paid by an insured or on behalf of an insured by another person for a prescription drug, including any amount paid under paragraph (a) of this subsection, when calculating an insured's contribution to any applicable cost-sharing requirement. The requirements of this paragraph shall not apply***:***

1. In the case of a prescription drug for which there is a generic alternative, unless the insured has obtained access to the brand prescription drug through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process; ***or***

2. To any fully insured health benefit plan or self-insured plan provided to any employee under KRS 18A.225;

(c) Prohibit a pharmacy from discussing any information under subsection (3) of this section; or

(d) Impose a penalty on a pharmacy for complying with this section.

(3) A pharmacist shall have the right to provide an insured information regarding the applicable limitations on his or her ***cost sharing***~~[cost-sharing]~~ pursuant to this section for a prescription drug.

(4) ***If the application of any requirement of subsection (2)(b) of this section would be the sole cause of a health plan's failure to qualify as a Health Savings Account-qualified High Deductible Health Plan under 26 U.S.C. sec. 223, as amended, then the requirement shall not apply to that health plan until the minimum deductible under 26 U.S.C. sec. 223, as amended, is satisfied***~~[Subsection (2)(b) of this section shall not apply to any fully insured health benefit plan or self-insured plan provided to an employee under KRS 18A.225]~~.

➔Section 2. KRS 205.532 is amended to read as follows:

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

(c) ***"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;***

(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)~~[(d)]~~ "Department" means the Department for Medicaid Services;

(f)~~[(e)]~~ "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;~~[and]~~

(g)~~[(f)]~~ "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) ~~[On and after January 1, 2019,]~~Every contract entered into or renewed ***on or after the effective date of this Act*** 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~~[304.17A-515]~~

(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) ~~[(3)]~~ (a) The department shall formally recognize a credentialing alliance formed ***by managed care organizations if*** ~~[in the private sector that is]~~:

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*** ~~[For the purpose of promoting a centralized process for credentialing providers]~~;

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*** ~~[health care provider]~~ trade association~~[that has at least one (1) year of experience providing credentialing services to at least one (1) Medicaid managed care organization in Kentucky]~~.

(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.

~~[(c) If on or before December 31, 2021, sixty percent (60%) or more, with any fraction of a percent rounded down, of the total number of Medicaid managed care organizations have entered into contracts with a credentialing alliance, the procurement provisions of this section shall be null and void and the department shall discontinue any contracts for credentialing verification services so that each Medicaid managed care organization shall bear its own costs for provider credentialing.]~~

(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) ~~[(d)]~~ 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*** ~~[subsection]~~, 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) ~~[(4)(a) 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 by a 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.~~

~~(b)~~ A Medicaid managed care organization shall:

(a) ~~[1.]~~ 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) ~~[2.]~~ ***1.*** ~~[a.]~~ 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. ~~[i.]~~ The accepted provider contract; and

b. ~~[ii.]~~ The provider as a participating provider.

2. ~~[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.

(8) ~~[(5)]~~ (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) ~~[(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 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) ~~[(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), ***(8)***~~[(5)]~~, and ***(9)***~~[(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.

(11)~~[(8)]~~ 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.

➔Section 3. In implementing the requirements of this Act, the state shall only regulate a pharmacy benefit manager or an insurer to the extent permissible under applicable law.

Became law without Governor's signature March 29, 2023.