COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

STEVEN L. BESHEAR
GOVERNOR

700 CAPITOL AVENUE
SUITE 100
FRANKFORT, KY 40601
(502) 564-2611
FAX: (502) 564-2517

VETO MESSAGE FROM THE GOVERNOR OF THE COMMONWEALTH OF KENTUCKY REGARDING HOUSE BILL 5 OF THE 2013 REGULAR SESSION

I, Steven L. Beshear, Governor of the Commonwealth of Kentucky, pursuant to the authority granted under Section 88 of the Kentucky State Constitution, do hereby veto the following:

House Bill 5 of the 2013 Regular Session of the General Assembly in its entirety.

I am vetoing this bill because, despite the commendable premise for the legislation, application of the law's provisions could increase the cost of managed care to the Commonwealth. The intent of HB 5 was to address concerns regarding the prompt payment by managed care organizations (MCOs) of provider claims for services rendered to Medicaid members by providing a review mechanism for those disputes in the Kentucky Department of Insurance. However, the provisions of the bill could have expanded those reviews far beyond true prompt payment disputes at significant cost to the state and might interfere with contractual rights presently existing between the providers and the MCOs. We can achieve the laudable goals of HB 5 through other means that will avoid these unintended consequences.

This the 5th day of April, 2013.

Steven L. Beshear, Governor

GENERAL ASSEMBLY
COMMONWEALTH OF KENTUCKY

2013 REGULAR SESSION

HOUSE BILL NO. 5

WEDNESDAY, FEBRUARY 27, 2013

The following bill was reported to the Senate from the House and ordered to be printed.

AN ACT relating to the prompt payment of Medicaid claims.

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

➔Section 1. KRS 304.17A-730 is amended to read as follows:

(1) An insurer that fails to pay, deny, or settle a clean claim in accordance with KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall pay interest according to the following schedule on the amount of the claim that remains unpaid:

(a) For claims that are paid between one (1) and thirty (30) days from the date that payment was due under KRS 304.17A-702, interest at a rate of twelve percent (12%) per annum shall accrue from the date payment was due under KRS 304.17A-702;

(b) For claims that are paid between thirty-one (31) and sixty (60) days from the date that payment was due under KRS 304.17A-702, interest at a rate of eighteen percent (18%) per annum shall accrue from the date payment was due under KRS 304.17A-702; and

(c) For claims that are paid more than sixty (60) days from the date payment was due under KRS 304.17A-702, interest at a rate of twenty-one percent (21%) per annum shall accrue from the date that payment was due under KRS 304.17A-702.

(2) When paying a claim after the time required by KRS 304.17A-702, the insurer shall add the interest payable to the amount of the unpaid claim without the necessity for any claim for that interest to be made by the provider filing the original claim. The interest obligation otherwise imposed by this section shall not apply if the failure to pay, deny, or settle a claim is due to, or results from, in whole or in part, acts or events beyond the control of the insurer, including but not limited to acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbance, riot, or complete or partial disruptions of facilities.

(3) (a) The commissioner of the Department of Insurance shall enforce the provisions of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 regarding the payment of health care claims by any health care provider rendering services for any provider partnership, health maintenance organization, or other managed care organization under contract with the Department for Medicaid Services to manage care and process health care claims for services delivered to Medicaid recipients covered under Medicaid managed care.

(b) 1. Any health care provider rendering services to a Medicaid recipient may file a complaint with the Department of Insurance for a failure to comply with prompt payment provisions:

a. Under the terms of the contract between:

i. A Medicaid managed care organization and a provider; or

ii. A Medicaid managed care organization and a member; or

b. Under KRS 304.17A-700 to 304.17A-730 or 304.14-135;

by any provider partnership, health maintenance organization, or other managed care organization under contract with the Department for Medicaid Services to manage care and process health care claims for services delivered to Medicaid recipients covered under Medicaid managed care.

2. A hearing may be requested for a claim designated "clean" but unpaid for thirty (30) or more days:

a. When the claim is denied ; or

b. Thirty (30) days after the claim is submitted by a provider.

3. a. A hearing may be requested for a claim designated "less than clean" or otherwise subject to delay of payment by a Medicaid managed care company after nonpayment for one hundred

twenty (120) days.

b. A Medicaid managed care company shall acknowledge the request for a hearing and within five (5) business days shall notify the provider, its billing agent, or designee that submitted the claim, in writing or electronically, of all information that is missing from the billing instrument, any errors in the billing instrument, or of any other circumstances which preclude it from being a clean claim.

4. A provider with more than one (1) denied claim for identical or similar services may request review of multiple claims in the same review process.

5. The Department of Insurance may charge a reasonable filing fee to offset its reasonable expenses in administering a hearing.

6. a. The Department of Insurance may investigate any issues identified as a result of a report, investigation, or hearing conducted under this subsection or subsection (4) of this section.

b. An eligible claim shall be filed with the Department of Insurance within thirty (30) days of becoming eligible under this paragraph or paragraph (c) of this subsection.

c. The Department of Insurance shall make a determination concerning whether a claim should be paid or not within thirty (30) days if no hearing is requested and within sixty (60) days if a hearing is requested.

7. The Department of Insurance and the Department for Medicaid Services are encouraged to forward any reporting documents utilized under this subsection or subsection (4) of this section to the Office of the State Auditor for review.

8. No provision of this subsection or subsection (4) of this section shall impact the claims payment or dispute procedures that relate to a fee-for-service Medicaid program administered by the cabinet.

(c) An interest rate of fourteen percent (14%) may be awarded after an administrative hearing and review on claims found to be unpaid in violation of:

1. The contract between the Medicaid managed care company and the Commonwealth;

2. A contract between the Medicaid managed care company and the provider;

3. A contract between the Medicaid managed care company and the member;

4. This subsection or subsection (4) of this section;

5. KRS 304.17A-700 to 304.17A-730; or

6. KRS 205.593.

(d) 1. The Department of Insurance's authority to enforce subsection (1) of this section shall include the authority to assess a fine of no more than one hundred dollars ($100) per violation when a Medicaid managed care company fails to comply with this section or KRS 304.17A-700 to 304.17A-730, 205.593, or 304.14-135.

2. Each day that a Medicaid managed care company fails to comply with this section or KRS Chapter 304.17A-700 to 304.17A-730, 205.593, or 304.14-135 shall count as a separate violation.

(4) (a) The commissioner of the Department of Insurance shall enforce the provisions of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135 and 304.99-123 regarding the payment of health benefit claims to any health care provider rendering services to Medicaid recipients for the

Department for Medicaid Services through a managed care organization under contract with the Commonwealth.

(b) Within sixty (60) days of the effective date of this Act, the Department of Insurance shall promulgate administrative regulations in accordance with KRS Chapter 13A to establish, implement, and operate by September 1, 2013, the internal appeals and hearing process for review of prompt payment claims under this section. Any administrative process conducted under this section shall be conducted in accordance with KRS Chapter 13B, except that any process established pursuant to this subsection shall guarantee the following:

1. The proper venue for an appeal following an administrative hearing or ruling shall be with the Franklin Circuit Court;

2. A claimant and the Medicaid managed care company may appear in person or through a designee to present evidence at the hearing;

3. The claimant and the Medicaid managed care company may subpoena witnesses, including expert witnesses, for the hearing; and

4. The hearing officer may request provision of evidence or appearance by witnesses and may subpoena relevant witnesses and evidence for the purposes of hearing and review.

➔Section 2. KRS 304.17A-722 is amended to read as follows:

(1) ~~[No later than ninety (90) days following July 15, 2002,]~~The department shall promulgate administrative regulations requiring all insurers to report information on a calendar quarter basis on prompt payment of claims to providers, as defined in KRS 304.17A-700, that shall be limited to the following:

(a) ***1.*** The number of ***original***~~[clean]~~ claims received by the insurer, its agent, or designee during the reporting period ***from a provider, its billing agent, or designee***;

and

2. The number of corrected claims received by the insurer, its agent, or designee during the reporting period from a provider, its billing agent, or designee including the number of times the corrected claim has been previously submitted to the insurer, its agent, or designee;

(b) The ***number and*** percentage of clean claims received by the insurer, its agent, or designee that were:

1. Adjudicated within the claims payment timeframe;
2. Adjudicated within one (1) to thirty (30) days from the end of the claims payment timeframe;
3. Adjudicated within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe;
4. Adjudicated within sixty-one (61) to ninety (90) days from the end of the claims payment timeframe;
5. Adjudicated more than ninety (90) days from the end of the claims payment timeframe; and
6. Not yet adjudicated;

(c) The ***number and*** percentage of clean claims received during the reporting quarter that were paid and not denied or contested:

1. Within the claims payment timeframe;
2. Within one (1) to thirty (30) days from the end of the claims payment timeframe;
3. Within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe;
4. Within sixty (60) to ninety (90) days from the end of the claims payment timeframe;
5. More than ninety (90) days from the end of the claims payment

timeframe; and

6. Not yet paid;

(d) Amount of interest paid; and

(e) For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount ***and the number*** of those claims that were paid within the claims payment timeframe.

(2) Data required in subsection (1) of this section shall be reported for hospitals, physicians, and all other providers, excluding pharmacies.

(3) ***The department shall promulgate administrative regulations requiring all insurers and entities that contract with insurers to provide pharmacy claims administration to report on a calendar quarter basis on payment of pharmacy claims.***

(4) Insurers shall submit information required in subsection (1) of this section to the department no later than ***ninety (90)***~~[one hundred eighty (180)]~~ days following the close of the reporting quarter.

(5)~~[(4)]~~ The department shall, as part of the market conduct survey of each insurer, audit the insurer to determine compliance with KRS 304.17A-700 to 304.17A-730 and KRS 304.14-135 and 304.99-123. Findings shall be made available to the public upon request.

(6)~~[(5)]~~ The commissioner shall annually present to the Interim Joint Committee on Banking and Insurance and to the Governor a report on the payment practices of insurers and compliance with the provisions of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 and the commissioner's enforcement activities, including the number of complaints received and those acted upon by the department.

➔Section 3. Those claims that are currently eligible for a hearing under Section 1 of this Act and any claims that become eligible after the effective date of this Act and

before the implementation of administrative regulations to govern the hearing process established in Section 1 of this Act shall be guaranteed interest under subsection (3)(c) of Section 1 of this Act and each day of nonpayment shall be eligible as a separate violation under subsection (3)(d) of Section 1 of this Act.

Speaker-House of Representatives

President of Senate

Attest: Jean T. Burgin
Chief Clerk of House of Representatives

Approved _____
Governor

Date _____