AN ACT relating to provider appeals for reimbursement by Medicaid managed care organizations.

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 this section:

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

(b) "Hearing officer" means an individual employed as a hearing officer by the Cabinet for Health and Family Services;

(c) "Medicaid managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2; and

(d) "Provider" means any person or entity under contract with a Medicaid managed care organization or its contractual agent that provides covered services to enrollees.

(2) Notwithstanding any law to the contrary, a provider who has exhausted the internal appeals process of a Medicaid managed care organization shall be entitled to an administrative appeals hearing on the Medicaid managed care organization's final decision of denial, nonpayment, or the amount of reimbursement to the provider for a health care service rendered by the provider to an enrollee of the Medicaid managed care organization.

(3) A Medicaid managed care organization's final decision letter of an appeal issued to a provider shall include:

(a) A statement that the provider has exhausted its internal appeal rights with the Medicaid managed care organization;

(b) A statement that the provider is entitled to an administrative appeals hearing which may be pursued by written request to the department; and

(c) The time period and address to request an administrative appeals hearing.

(4) A provider may make a written request for an administrative appeals hearing within thirty (30) days of the provider's receipt of the Medicaid managed care organization's final decision.

(5) An administrative hearing for a provider appeal shall be conducted by a hearing officer in accordance with KRS Chapter 13B and shall comply with the following requirements:

(a) Failure by either a Medicaid managed care organization or a provider to attend a required conference or hearing related to an appeal shall result in disposition of the appeal in favor of the other party; and

(b) The hearing officer shall issue a recommended order within thirty (30) calendar days from the date the administrative appeals hearing request is received by the department. The hearing officer may extend this deadline for up to fourteen (14) days.

(6) A Medicaid managed care organization shall reimburse a provider for reasonable and necessary attorneys' fees at the state rate as established by the Government Contract Review Committee of the Legislative Research Commission, and administrative costs expended by a provider to pursue an administrative appeals hearing under this section if the recommended order awards more than fifty percent (50%) of the dollar amount involved to the provider.

(7) The party that does not prevail shall pay a fee of one hundred dollars ($100) to the cabinet.

(8) The department shall promulgate administrative regulations to implement the administrative appeals hearing process for provider reimbursement as required by this section.

➔Section 2. This Act applies to all contracts between Medicaid managed care organizations and the Department for Medicaid Services entered into or renewed on or

after July 1, 2015.

➔Section 3. This Act takes effect July 1, 2015.