AN ACT relating to medical coverage.

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

➔Section 1. KRS 304.17A-254 is amended to read as follows:

An insurer that offers a health benefit plan that is not a managed care plan but provides financial incentives for a covered person to access a network of providers shall:

(1) Notify the covered person, in writing, of the availability of a printed document, in a manner consistent with KRS 304.14-420 to 304.14-450, containing the following information at the time of enrollment and upon request:

(a) A current directory of the in-network providers from which the covered person may access covered services at a financially beneficial rate. The directory shall, at a minimum, provide the name, type of provider, professional office address, telephone number, and specialty designations of the network provider, if any; and

(b) In addition to making the information available in a printed document, an insurer may also make the information available in an accessible electronic format;

(2) Assure that contracts with the providers in the network contain a hold harmless agreement under which the covered person will not be balanced billed by the in-network provider except for deductibles, co-pays, coinsurance amounts, and noncovered benefits;

(3) File with the department a copy of the directory required under subsection (1) of this section;

(4) Have a process for the selection of health care providers who will be on the insurer's list of participating providers, with written policies and procedures for review and approval used by the insurer. The insurer shall establish minimum professional requirements for participating health care providers. An insurer may not discriminate against a provider solely on the basis of the provider's license by the

state;

(5) Not contract with a health care provider to limit the provider's disclosure to a covered person, or to another person on behalf of a covered person, of any information relating to the covered person's medical condition or treatment options;

(6) Not penalize a health care provider, or terminate a health care provider's contract with the insurer, because the provider discusses medically necessary or appropriate care with a covered person or another person on behalf of a covered person. The health care provider may:

(a) Not be prohibited by the insurer from discussing all treatment options with the covered person; and

(b) Disclose to the covered person or to another person on behalf of a covered person other information determined by the health care provider to be in the best interests of the covered person;

(7) Include in any agreements it enters into with providers for the provision of health care services a clause stating that the insurer will, upon request of a health care provider, provide or make available to a health care provider, when contracting or renewing an existing contract with such provider, the payment or fee schedules or other information sufficient to enable the health care provider to determine the manner and amount of payments under the contract for the health care provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety (90) days prior to the effective date of the amendment pursuant to KRS 304.17A-577;

(8) ***Establish a policy governing the procedures for changing an existing agreement with a provider that shall include but are not limited to:***

(a) The requirement of a face-to-face meeting to discuss proposed changes if requested by medical provider;

(b) The requirement of a certified letter detailing proposed changes;

(c) The requirement of a provider to either agree or not agree to proposed changes; and

(d) The requirement that a new agreement be established and agreed upon after three (3) or more changes are made to an existing agreement.

(9) Establish a policy governing the removal of and withdrawal by health care providers from the provider network that includes the following:

(a) The insurer shall inform a participating health care provider of the insurer's removal and withdrawal policy at the time the insurer contracts with the health care provider to participate in the provider network, and when changed thereafter;

(b) If a participating health care provider's participation will be terminated or withdrawn prior to the date of the termination of the contract as a result of a professional review action, the insurer and participating health care provider shall comply with the standards in 42 U.S.C. sec. 11112; and

(c) If the insurer finds that a health care provider represents an imminent danger to an individual patient or to the public health, safety, or welfare, the medical director shall promptly notify the appropriate professional state licensing board; and

(10) ~~[(9)]~~ Meet all requirements provided under KRS 304.17A-600 to 304.17A-633 and KRS 304.17A-700 to 304.17A-730.

➔Section 2. KRS 304.17A-545 is amended to read as follows:

(1) A managed care plan shall appoint a medical director who:

(a) Is a physician licensed to practice in this state;

(b) Is in good standing with the State Board of Medical Licensure;

(c) Has not had his or her license revoked or suspended, under KRS 311.530 to 311.620;

(d) Shall sign any denial letter required under KRS 304.17A-540; and

(e) Shall be responsible for the treatment policies, protocols, quality assurance activities, and utilization management decisions of the plan.

(2) The medical director shall ensure that:

(a) Any utilization management decision to deny, reduce, or terminate a health care benefit or to deny payment for a health care service because that service is not medically necessary shall be made by a physician, except in the case of a health care service rendered by a chiropractor or optometrist, that decision shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky;

(b) A utilization management decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the insurer for those services, unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person or the participating provider;

(c) In the case of a managed care plan, a procedure is implemented whereby participating physicians have an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and whereby other participating providers have an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice;

(d) The utilization management program is available to respond to authorization requests for urgent services and is available, at a minimum, during normal working hours for inquiries and authorization requests for nonurgent health care services; and

(e) In the case of a managed care plan, a covered person is permitted to choose or change a primary care provider from among participating providers in the provider network and, when appropriate, choose a specialist from among

participating network providers following an authorized referral, if required by the insurer, and subject to the ability of the specialist to accept new patients.

(3) A managed care plan shall develop comprehensive quality assurance or improvement standards adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of health care services. These standards shall be made available to the public during regular business hours and include:

(a) An ongoing written, internal quality assurance or improvement program;

(b) Specific written guidelines for quality of care studies and monitoring, including attention to vulnerable populations;

(c) Performance and clinical outcomes-based criteria;

(d) A procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

(e) A plan for data gathering and assessment; and

(f) A peer review process.

(4) Each managed care plan shall have a process for the selection of health care providers who will be on the plan's list of participating providers, with written policies and procedures for review and approval used by the plan.

(a) The plan shall establish minimum professional requirements for participating health care providers. An insurer may not discriminate against a provider solely on the basis of the provider's license by the state;

(b) The plan shall demonstrate that it has consulted with appropriately qualified health care providers to establish the minimum professional requirements;

(c) The plan's selection process shall include verification of each health care provider's license, history of license suspension or revocation, and liability claims history;

(d) A managed care plan shall establish a formal written, ongoing process for the reevaluation of each participating health care provider within a specified

number of years after the provider's initial acceptance into the plan. The reevaluation shall include an update of the previous review criteria and an assessment of the provider's performance pattern based on criteria such as enrollee clinical outcomes, number of complaints, and malpractice actions.

(5) The commissioner shall promulgate administrative regulations to establish a uniform application form and guidelines for the evaluation and reevaluation of health care providers, including psychologists, who will be on the plan's list of participating providers in accordance with subsection (4) of this section. In developing a uniform application and guidelines, the department shall consider industry standards and guidelines adopted by the Council for Affordable Quality Healthcare. The uniform application form and guidelines shall be used by all insurers.

(6) ***Each managed care plan shall establish a policy governing the procedures for changing an existing agreement with a provider that shall include but are not limited to:***

(a) The requirement of a face-to-face meeting to discuss proposed changes if requested by medical provider;

(b) The requirement of a certified letter detailing proposed changes;

(c) The requirement of a provider to either agree or not agree to proposed changes; and

(d) The requirement that a new agreement be established and agreed upon after three (3) or more changes are made to an existing agreement.

(7) A managed care plan shall not use a health care provider beyond, or outside of, the provider's legally authorized scope of practice.

➔Section 3. This Act takes effect January 1, 2016.