1 AN ACT relating to service improvements in the Medicaid program.

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

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

5 ***(1) The Commonwealth shall limit the total number of awarded Medicaid managed***
6 ***care contracts to administer the Medicaid program to no more than two (2)***
7 ***managed care organizations, except as provided in subsections (4) and (5) of this***
8 ***section.***

9 ***(2) Notwithstanding any state law to the contrary, in evaluating which two (2)***
10 ***managed care organizations to select for future contracts with the***
11 ***Commonwealth, the selecting state government agency shall establish a rating***
12 ***scale to evaluate current or new entities that have bid to operate as a Medicaid***
13 ***managed care organization within the Commonwealth. This rating scale shall be***
14 ***the method used by the selecting state government agency to select the two (2)***
15 ***managed care organizations to operate the Medicaid program. The two (2)***
16 ***highest-scoring managed care organizations under the criteria established in the***
17 ***rating scale shall be awarded the contracts to operate the Medicaid program.***

18 ***(3) The rating scale and the selecting state government agency shall utilize the***
19 ***following information to assess the applying managed care organizations when***
20 ***an applying managed care organization has previously provided Medicaid***
21 ***managed care to Medicaid members within the Commonwealth:***

22 ***(a) 1. Five percent (5%) of the rating shall be based on the medical loss ratio***
23 ***data provided by the Department for Medicaid Services. Information***
24 ***relating to the actual medical loss ratio of each managed care***
25 ***organization as it performs contracts to provide Medicaid services***
26 ***shall be provided by the Department for Medicaid Services.***

27 ***2. The managed care organization with the highest medical loss ratio as***

1 measured pursuant to this paragraph shall receive a score of one
2 hundred percent (100%) of the score available pursuant to this
3 paragraph.
4 3. The managed care organization with the second highest medical loss
5 ratio as measured pursuant to this paragraph shall receive a score of
6 not less than ninety-five percent (95%) of the score available pursuant
7 to this paragraph.
8 4. The remaining managed care organizations with lower medical loss
9 ratios than both of the managed care organizations designated
10 pursuant to subparagraphs 2. and 3. of this paragraph shall receive
11 scores of not more than eighty-five percent (85%) of the score
12 available pursuant to this paragraph;
13 (b) 1. Twenty percent (20%) of the rating shall be based on the quality and
14 access measures scores developed and provided by the Department for
15 Medicaid Services that are used by members to select a managed care
16 organization.
17 2. The highest-rated managed care organization pursuant to this
18 paragraph shall receive a score of one hundred percent (100%) of the
19 score available pursuant to this paragraph.
20 3. The second-highest-scoring managed care organization pursuant to
21 this paragraph shall receive a score of not less than ninety-five percent
22 (95%) of the score available pursuant to this paragraph.
23 4. The remaining managed care organizations shall receive scores of not
24 more than eighty-five percent (85%) of the score available pursuant to
25 this paragraph;
26 (c) 1. Twelve and one-half percent (12.5%) of the rating scale shall be based
27 on the numbers and severity of corrective actions taken against a

1 ***managed care organization when the Department for Medicaid***
2 ***Services has found that the managed care organization was violating***
3 ***its contract with the state to provide Medicaid services. The corrective***
4 ***actions considered shall include letters of concern issued, corrective***
5 ***action plans required, sanctions issued, and cease-and-desist orders***
6 ***issued.***
7 ***2. The managed care organization with the least number and severity of***
8 ***corrective actions issued shall receive a score of one hundred percent***
9 ***(100%) of the score available pursuant to this paragraph.***
10 ***3. The managed care organization with the second-lowest number and***
11 ***severity of corrective actions issued shall receive a score of not less***
12 ***than ninety-five percent (95%) of the score available pursuant to this***
13 ***paragraph.***
14 ***4. The remaining managed care organizations with the higher corrective***
15 ***actions issued and higher severity of corrective actions shall receive***
16 ***scores of not more than eighty-five percent (85%) of the score***
17 ***available pursuant to this paragraph;***
18 ***(d) 1. Twelve and one-half percent (12.5%) of the rating scale shall be based***
19 ***on the aggregate percentage of prompt payment of clean claims within***
20 ***thirty (30) days by each managed care organization over the time that***
21 ***the managed care organization has operated in the Commonwealth.***
22 ***2. The managed care organization with the highest percentage of clean***
23 ***claims paid promptly within thirty (30) days over the entirety of the***
24 ***time that the managed care organization has provided Medicaid***
25 ***managed care within the Commonwealth shall receive a score of one***
26 ***hundred percent (100%) of the score available pursuant to this***
27 ***paragraph.***

1 ***3. The managed care organization with the second-highest percentage of***
2 ***clean claims paid promptly within thirty (30) days over the entirety of***
3 ***the time that the managed care organization has provided Medicaid***
4 ***managed care within the Commonwealth shall receive a score of not***
5 ***less than ninety-five percent (95%) of the score available pursuant to***
6 ***this paragraph.***
7 ***4. The remaining managed care organizations with lower percentages of***
8 ***clean claims paid promptly within thirty (30) days over the entirety of***
9 ***the time that the managed care organizations have provided Medicaid***
10 ***managed care within the Commonwealth shall receive no more than***
11 ***eighty-five percent (85%) of the score available pursuant to this***
12 ***paragraph; and***
13 ***(e) The remaining fifty percent (50%) of the rating scale shall follow the***
14 ***existing request for proposal procurement process that complies with KRS***
15 ***Chapter 45A in the following manner:***
16 ***1. The lowest bid shall be assigned a score of one hundred percent***
17 ***(100%) of the score available within this paragraph;***
18 ***2. Bids that are within one hundred and twenty-five percent (125%) of***
19 ***the lowest bid received shall be scored under this paragraph at a two***
20 ***percent (2%) reduction in score for every ten percent (10%) exceeding***
21 ***the lowest received bid;***
22 ***3. Bids that are between one hundred twenty-five percent (125%) and***
23 ***one hundred fifty percent (150%) of the lowest bid received shall be***
24 ***scored under this paragraph at a five percent (5%) reduction in score***
25 ***for every ten percent (10%) exceeding the lowest received bid; and***
26 ***4. Bids that are greater than one hundred fifty percent (150%) of the***
27 ***lowest bid received shall be scored under this paragraph at a ten***

1 *percent (10%) reduction in score for every ten percent (10%)*
2 *exceeding the lowest received bid.*
3 *(4) A managed care organization that is commencing operation as a managed care*
4 *organization in the Commonwealth and which has no history as a managed care*
5 *organization in the Commonwealth or United States and is not substantially*
6 *similar to a previous managed care organization operating in the Commonwealth*
7 *may be considered under the rating scale established in subsection (3) of this*
8 *section as follows:*
9 *(a) The managed care organization shall submit the lowest bid received*
10 *pursuant to the request-for-proposal procurement process that complies*
11 *with KRS Chapter 45A;*
12 *(b) If the managed care organization that is commencing initial operation in*
13 *the Commonwealth is selected then the Department for Medicaid Services*
14 *shall conduct full audits at least once every two (2) months for the duration*
15 *of the new managed care organization's contract to assess and calculate the*
16 *managed care organization's performance in the metrics measured in*
17 *paragraphs (a), (b), (c), and (d) of subsection (3) of this section. If the*
18 *managed care organization's performance under the metrics when*
19 *combined with its score under paragraph (e) of subsection (3) of this section*
20 *in any four (4) month period does not result in the highest or second-*
21 *highest score when recalculated, then the managed care organization's*
22 *contract shall be immediately terminated and the existing Medicaid*
23 *managed care organizations shall be assigned all members of the*
24 *terminated managed care organization; and*
25 *(c) Because of the risk of contract termination under this subsection, if the*
26 *Department for Medicaid Services awards a contract under this subsection,*
27 *then it may issue three (3) contracts to provide Medicaid managed care*

1 ***services for the duration of that contract. The third managed care***
2 ***organization offered a contract shall be the organization that received the***
3 ***third-highest rating under the rating scale established in subsection (3) of***
4 ***this section.***
5 ***(5) A managed care organization that has not previously provided managed care***
6 ***services to Medicaid members in the Commonwealth but that has provided***
7 ***managed care services to Medicaid members in other states may be considered***
8 ***under the rating scale established in subsection (3) of this section as follows:***
9 ***(a) The managed care organization shall submit a bid that is at least within ten***
10 ***percent (10%) of the lowest bid received pursuant to the request-for-***
11 ***proposal procurement process that complies with KRS Chapter 45A;***
12 ***(b) The managed care organization shall submit or reference data measures***
13 ***that are the same or similar to the data requested in paragraphs (a), (b), (c),***
14 ***and (d) of subsection (3) of this section;***
15 ***(c) The Department for Medicaid Services shall analyze the bid by the managed***
16 ***care organization that is entering the Kentucky market for the first time and***
17 ***determine if the data submitted by the managed care organization in***
18 ***paragraphs (a) and (b) of this subsection constitutes a bid that would be in***
19 ***the top highest-scoring bids pursuant to the rating scale established in***
20 ***subsection (3) of this section;***
21 ***(d) If the managed care organization that is entering the Kentucky market for***
22 ***the first time is selected, then the Department for Medicaid Services shall***
23 ***conduct full audits at least once every two (2) months for the duration of the***
24 ***new managed care organization's contract to assess and calculate the***
25 ***managed care organization's performance in the metrics measured in***
26 ***paragraphs (a), (b), (c), and (d) of subsection (3) of this section. If the***
27 ***managed care organization's performance under the metrics, when***

1 ***combined with its score under paragraph (e) of subsection (3) of this section***
2 ***in any four (4) month period, does not result in the highest-or second-***
3 ***highest score when recalculated then the managed care organization's***
4 ***contract shall be immediately terminated, and the existing Medicaid***
5 ***managed care organizations shall be assigned all members of the***
6 ***terminated managed care organization; and***
7 ***(e) Because of the risk of contract termination under this subsection, if the***
8 ***Department for Medicaid Services awards a contract to a managed care***
9 ***organization under this subsection, then it may issue three (3) contracts to***
10 ***provide Medicaid managed care services for the duration of that contract.***
11 ***The third managed care organization offered a contract shall be the***
12 ***organization that received the third-highest rating under the rating scale***
13 ***established in subsection (3) of this section.***
14 ➔SECTION 2. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
15 READ AS FOLLOWS:
16 ***(1) Any Medicaid managed care organization contracted to provide Medicaid***
17 ***services shall, on a quarterly basis, provide all payment schedules utilized to***
18 ***reimburse for Medicaid services within the Commonwealth over the previous***
19 ***three (3) months to the Medicaid Oversight and Advisory Committee.***
20 ***(2) The Cabinet for Health and Family Services shall require that each Medicaid***
21 ***service provided by a rural provider within a rural county be reimbursed at least***
22 ***at the median amount paid to an urban health care provider for the same service***
23 ***within the nearest metropolitan statistical area to the rural county where the***
24 ***service was performed.***
25 ***(3) (a) If the Cabinet for Health and Family Services discovers or is made aware of***
26 ***an underpayment that occurred pursuant to subsection (2) of this section,***
27 ***including via analysis of data provided pursuant to subsection (1) of this***

1 ***section, then the Cabinet for Health and Family Services shall require the***
2 ***Medicaid managed care organization that committed the underpayment to***
3 ***correct that underpayment within thirty (30) days.***
4 ***(b) If an underpayment is not corrected within thirty (30) days, then the***
5 ***managed care organization shall pay three (3) times the interest rate***
6 ***established in KRS 304.17A-730 to the provider that was underpaid***
7 ***pursuant to this section.***