AN ACT relating to the Medicaid program.

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, unless the context requires otherwise:

(a) "Managed care organization" has the same meaning as in KRS 205.532;

(b) "Material change" means a change to a contract, the occurrence and timing of which is not otherwise clearly identified in the contract, that decreases the health care provider's payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense, and includes any changes to provider network requirements or inclusion in any new or modified insurance products; and

(c) "Participating provider" means a Medicaid credentialed and enrolled provider of health services.

(2) Each managed care organization shall establish procedures for changing an existing agreement with a participating provider that shall comply with the requirements of this section.

(3) (a) If a managed care organization makes any material change to an agreement it has entered into with a participating provider for the provision of Medicaid-covered services, the managed care organization shall provide the participating provider with at least ninety (90) days notice of the material change.

(b) The notice of a material change required shall:

1. Provide the proposed effective date of the change;

2. Include a description of the material change;

3. Include a statement that the participating provider has the option to

either accept or reject the proposed material change in accordance with this section;

4. Provide the name, business address, telephone number, and email address of a representative of the managed care organization to discuss the material change, if requested by the participating provider;

5. a. Provide notice of the opportunity for a meeting using real-time communication to discuss the proposed changes if requested by the participating provider. If requested by the provider, the opportunity to communicate to discuss the proposed changes may occur via email instead of real-time communication.

b. For purposes of this subparagraph, "real-time communication" means any mode of telecommunications in which all users can exchange information instantly or with negligible latency and includes the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing; and

6. Provide notice that upon three (3) material changes in a twelve (12) month period, the provider may request a copy of the contract with material changes consolidated into it. Provision of the copy of the contract by the managed care organization shall be for informational purposes only and shall have no effect on the terms and conditions of the contract.

(c) A managed care organization shall utilize a method of delivery of the material change notice that provides confirmation receipt by the participating provider evidenced by a written or electronic signature.

(d) The notice of proposed material change shall be sent in an orange-colored envelope with the phrase "ATTENTION! CONTRACT AMENDMENT ENCLOSED!" in no less than fourteen (14) point boldface Times New

Roman font printed on the front of the envelope. This color of envelope shall be used for the sole purpose of communicating proposed material changes and shall not be used for other types of communication from an insurer.

(4) If a material change relates to the participating provider's inclusion in any new or modified insurance products, or proposes changes to the participating provider's membership networks:

(a) The material change shall only take effect upon the acceptance of the participating provider, evidenced by a written signature; and

(b) The notice of the proposed material change shall be sent by certified mail, return receipt requested to the participating provider's point of contact, as set forth in the agreement, and to the provider's principal place of business as it appears on the Secretary of State's website, if the provider is an entity required to register with the Secretary of State's office as a business entity.

(5) For any other material change not addressed in subsection (4) of this section:

(a) The material change shall take effect on the date provided in the notice unless the participating provider objects to the change in accordance with this subsection;

(b) A participating provider who objects under this subsection shall do so in writing and the written protest shall be delivered to the managed care organization within thirty (30) days of the participating provider's receipt of notice of the proposed material change;

(c) Within thirty (30) days following the managed care organization's receipt of the written objection, the managed care organization and the participating provider shall confer in an effort to reach an agreement on the proposed change or any counter-proposals offered by the participating provider;

(d) If the managed care organization and participating provider fail to reach an

agreement during the thirty (30) day negotiation period described in paragraph (c) of this subsection, then the parties shall unwind their relationship, provide notice to patients and other affected parties, and terminate the contract pursuant to its original terms within thirty (30) days; and

(e) The managed care organization shall be limited to no more than one (1) material change during the term of the contract and may not reduce the provider's payment or compensation by more than ten percent (10%) of the provider's prior payment or compensation.

(6) If a managed care organization makes a change to an agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, the managed care organization shall provide notice of the change to the participating provider at least fifteen (15) days prior to the change.

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

Any contract entered into or renewed by the Cabinet for Health and Family Services, or any department, division, or unit thereof, on or after the effective date of this Act for the delivery of Medicaid services by a managed care organization shall:

(1) Be in compliance with 42 U.S.C. sec. 1396u-2 and 42 C.F.R. pt. 438, subpart K, including but not limited to federal provisions related to amending contracts between the Department for Medicaid Services and managed care organizations;

(2) Require managed care organizations to ensure that financial requirements and treatment limitations applicable to benefits covering the treatment of a mental health condition are no more restrictive than those applicable to the treatment of a physical health condition;

(3) Include processes and procedures that shall be utilized by the Department for

Medicaid Services to ensure and monitor compliance with requirements established in 42 C.F.R. pt. 438, subpart K and subsection (2) of this section;

(4) Require each managed care organization to submit to the Department for Medicaid Services any analyses, reports, data, or other information that the department determines may be necessary for the processes and procedures described in subsection (3) of this section; and

(5) Require each managed care organization to submit an annual report to the department on or before April 1 of each year that contains the following:

(a) A comparative analysis of nonquantitative limitations that complies with 42 U.S.C. sec. 300gg-26(a)(8); and

(b) A comparison of payments made to all physical health providers, by provider type, and all mental health providers, by provider type as indexed to the national Medicare physicians fee schedule for the calendar year covered by the report.

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

(1) Beginning July 1, 2027, in order to be eligible for reimbursement by the Department for Medicaid Services or a managed care organization with whom the department has contracted for the delivery of Medicaid services:

(a) A program operated by an agency licensed under KRS 222.231 shall be fully accredited by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation, or another nationally recognized accrediting organization with comparable standards approved by the Department for Medicaid Services pursuant to subsection (3) of this section; and

(b) A narcotic treatment program shall be licensed by the cabinet.

(2) Narcotic treatment programs licensed by the cabinet may utilize buprenorphine

products approved by the United States Food and Drug Administration for the treatment of substance use disorders.

(3) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A necessary to carry out the provisions of this section, including but not limited to administrative regulations related to the licensing of narcotic treatment programs and the certification of programs operated by agencies licensed under KRS 222.231.

➔Section 4. KRS 205.522 is amended to read as follows:

(1) With respect to the administration and provision of Medicaid benefits pursuant to this chapter, the Department for Medicaid Services, any managed care organization contracted to provide Medicaid benefits pursuant to this chapter, and the state's medical assistance program shall be subject to, and comply with, ***all provisions of this chapter related to the state's medical assistance program and*** the following, as applicable:

(a) KRS 304.17A-129;

(b) KRS 304.17A-145;

(c) KRS 304.17A-163;

(d) KRS 304.17A-1631;

(e) KRS 304.17A-167;

(f) ~~[KRS 304.17A-235;~~

~~(g)]~~KRS 304.17A-257;

(g) ~~[(h)]~~ KRS 304.17A-259;

(h) ~~[(i)]~~ KRS 304.17A-263;

(i) ~~[(j)]~~ KRS 304.17A-264;

(j) ~~[(k)]~~ KRS 304.17A-515;

(k) ~~[(l)]~~ KRS 304.17A-580;

(l) ~~[(m)]~~ KRS 304.17A-600, 304.17A-603, and 304.17A-607;~~[and]~~

(m) KRS 304.17A-661;

(n) KRS 304.17A-700 to 304.17A-730; and

(o) ~~[(n)]~~ KRS 304.17A-740 to 304.17A-743.

(2) A managed care organization contracted to provide Medicaid benefits pursuant to this chapter shall***:***

(a) Comply with the reporting requirements of KRS 304.17A-732***; and***

(b) In addition to complying with KRS 304.17A-706 as required by subsection (1) of this section, provide a detailed description of the reasons for denial of claims contested under KRS 304.17A-706(1). The description of reasons for denial shall include:

1. Any information that was required to be received, but was not received, in the health claim attachment;

2. The reason each claim was determined not to be medically necessary; and

3. The specific law, regulation, policy, guidance, literature, publication, standard of practice, or other authority the managed care organization relied upon to determine that a claim was not medically necessary.

➔Section 5. KRS 205.533 is amended to read as follows:

(1) ~~[By January 1, 2019,]~~A managed care organization shall establish an interactive ***website*** ~~[Web site]~~, operated by the managed care organization, that allows providers to file grievances, appeals, and supporting documentation electronically in an encrypted format that complies with federal law and that allows a provider to review the current status of a matter relating to an appeal or a grievance filed concerning a submitted claim.

(2) Each managed care organization's website, established in accordance with subsection (1) of this section shall include, in a highly visible and easily accessible manner, the following:

(a) The names of the managed care organization's:

1. Provider relations representatives for behavioral health;

2. Provider relations representatives for physical health; and

3. Provider contract representatives for provider contract changes;

(b) The email address and telephone number for each individual described in paragraph (a) of this subsection; and

(c) A detailed explanation, written in plain and simple to understand language, of the managed care organization's process for:

1. Internal appeals; and

2. Providers to request an external, independent third-party review.

(3) Information required to be accessible on a managed care organization's website pursuant to subsection (2) of this section shall be kept current and updated within thirty (30) days of any change to the information.

➔Section 6. KRS 205.534 is amended to read as follows:

(1) A Medicaid managed care organization ***with whom the Department for Medicaid Services contracts for the delivery of Medicaid services*** shall:

(a) Provide:

1. A toll-free telephone line for providers to contact the insurer for claims resolution for forty (40) hours a week during normal business hours in this state;

2. A toll-free telephone line for providers to submit requests for authorizations of covered services during normal business hours and extended hours in this state on Monday and Friday through 6 p.m., including federal holidays;

3. With regard to any adverse payment or coverage determination, copies of all documents, records, and other information relevant to a determination, including medical necessity criteria and any processes,

strategies, or evidentiary standards relied upon, if requested by the provider. Documents, records, and other information required to be provided under this paragraph shall be provided at no cost to the provider; and

4. For any adverse payment or coverage determination, a written reply in sufficient detail to inform the provider of all reasons for the determination. The written reply shall include information about the provider's right to request and receive at no cost to the provider documents, records, and other information under subparagraph 3. of this paragraph;

(b) Afford each participating provider the opportunity for an in-person meeting with a representative of the managed care organization on:

1. Any clean claim that remains unpaid in violation of KRS 304.17A-700 to 304.17A-730; and

2. Any claim that remains unpaid for forty-five (45) days or more after the date the claim is received by the managed care organization and that individually or in the aggregate exceeds two thousand five hundred dollars ($2,500);

(c) Reprocess claims that are incorrectly paid or denied in error, in compliance with KRS 304.17A-708. The reprocessing shall not require a provider to rebill or resubmit claims to obtain correct payment. No claim shall be denied for timely filing if the initial claim was timely submitted;~~[and]~~

(d) Establish processes for internal appeals, including provisions for:

1. Allowing a provider to file any grievance or appeal related to the reduction or denial of the claim within ***one hundred twenty (120)***~~[sixty (60)]~~ days of receipt of a notification from the managed care organization that payment for a submitted claim has been reduced or

denied;~~[and]~~

2. ***a.*** Ensuring the timely consideration and disposition of any grievance or any appeal within thirty (30) days from the date the grievance or appeal is filed with the managed care organization by a provider under this paragraph.

b. Failure of the managed care organization to comply with subdivision a. of this subparagraph shall result in:

i. A fine or penalty as provided for in subsection (6) of this section; or

ii. If related to an unresolved appeal, granting the provider's appeal to reimburse and reversal of the managed care organization's reduction or denial of the claim; and

3. Ensuring that, following the resolution of an appeal that results in a determination that a monetary amount is owed to a provider, payment is made in full to the provider within thirty (30) days from the date on which the appeal was resolved. Payments required under this subparagraph shall include:

a. The monetary amount determined to be owed to the provider plus twelve percent (12%) interest; and

b. If applicable, reasonable attorney's fees incurred by the provider to appeal the managed care organization's denial; and

(e) With regard to provider audits:

1. a. Ensure, except as provided in subdivision b. of this subparagraph, that audit requests are reasonable in regard to the number of providers being audited, the number of records being audited, and the timeframe audit records cover by utilizing a valid sampling methodology to determine which providers may

be audited, the number of records that may be audited, and the timeframe covered by records that may be audited.

b. The requirement that audit decisions be based on a valid sampling methodology shall not apply to cases in which an allegation of fraud, willful misrepresentation, or abuse is made by the managed care organization.

c. A managed care organization shall notify the Department for Medicaid Services of any allegations of fraud, willful misrepresentation, or abuse prior to initiating a provider audit;

2. Provide written notification to a provider that he or she is being audited. The written notification shall include:

a. The date the written notification was sent to the provider;

b. An explanation of the purpose of the audit;

c. The number of records being audited;

d. The timeframe covered by the records being audited;

e. The number of calendar days the provider shall be allowed, in accordance with subparagraph 3. of this paragraph, to provide or grant access to the requested records;

f. The managed care organization's or, if the managed care organization has contracted with a third-party to conduct the audit, the third-party entity's point of contact for the audit, including the individual's name, telephone number, mailing address, email address, and fax number; and

g. Complete written instructions for filing an appeal including the appeal shall be submitted by the provider to the managed care organization or, if the managed care organization has contracted with a third-party to conduct the audit, the third-party entity;

3. Allow at least thirty (30) calendar days for a provider to provide or grant access to the requested records, except that a provider shall be allowed:

a. A minimum of sixty (60) calendar days if more than thirty (30) records are being requested or if the timeframe the records cover is more one (1) year; and

b. Additional time beyond the minimally required thirty (30) or sixty (60) calendar days if the provider provides justification for the need for additional time;

4. Limit the timeframe of records requested as part of an audit to not more than two (2) years from the date on which a claim was submitted for payment, except that a longer timeframe shall be permitted if allowed under federal law or if there is evidence of fraud. If evidence of fraud exists, the managed care organization shall notify the Department for Medicaid Services of the evidence of fraud prior to initiating a provider audit;

5. Complete an audit within one hundred twenty (120) calendar days from the date on which the written audit notification required under subparagraph 2. of this paragraph was sent to the provider;

6. Provide written findings of a completed audit to the provider within thirty (30) calendar days of date on which the audit was completed. Written audit findings shall:

a. Include the name, phone number, mailing address, email address, and fax number of the manage care organization's or, if the managed care organization has contracted with a third-party to conduct the audit, the third-party entity's point of contact responsible for the audit findings;

b. Provide claims-level detail of the amounts and reasons for each claim recovery found to be due; and

c. Clearly state if no amounts have been found to be due;

7. a. Exempt, as provided in subparagraph 8. of this paragraph, a provider from recoupment of funds if an audit results in the identification of any clerical or recordkeeping errors, including typographical errors, scrivener's errors, omissions, or computer errors, unless the auditing entity provides proof of intent to commit fraud or the error results in an actual overpayment to the provider.

b. If an auditing entity discovers or is otherwise in possession of proof of intent to commit fraud, the auditing entity shall immediately notify the Department for Medicaid Services;

8. Allow the provider to submit amended claims within thirty (30) calendar days of the discovery of a clerical or recordkeeping error in lieu of recoupment if the services were otherwise provided in accordance with state and federal law;

9. Not receive payment based on the amount recovered in the audit;

10. Only recoup funds from a provider upon the final disposition of the audit including the appeals process as established in KRS 205.646; and

11. Base recoupment of claims on the actual overpayment or underpayment of claims unless the provider agrees to a settlement to the contrary.

(2) (a) For the purposes of this subsection:

1. "Timely" means that an authorization or preauthorization request shall be approved:

a. For an expedited authorization request, within seventy-two (72) hours after receipt of the request. The timeframe for an expedited authorization request may be extended by up to fourteen (14) days if:

i. The enrollee requests an extension; or

ii. The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and

b. For a standard authorization request, within two (2) business days. The timeframe for a standard authorization request may be extended by up to fourteen (14) additional days if:

i. The provider or enrollee requests an extension; or

ii. The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and

2. a. "Expedited authorization request" means a request for authorization or preauthorization where the provider determines that following the standard a timeframe could seriously jeopardize an enrollee's life or health, or ability to attain, maintain, or regain maximum function.~~[; and]~~

b. A request for authorization or preauthorization for treatment of an enrollee with a diagnosis of substance use disorder shall be considered an expedited authorization request by the provider and the managed care organization.

(b) A decision by a managed care organization on an authorization or preauthorization request for physical, behavioral, or other medically necessary services shall be made in a timely and consistent manner so that Medicaid

members with comparable medical needs receive a comparable, consistent level, amount, and duration of services as supported by the member's medical condition, records, and previous affirmative coverage decisions.

(3) (a) Each managed care organization shall report on a monthly basis to the department:

1. The number and dollar value of claims received that were denied, suspended, or approved for payment;
2. The number of requests for authorization of services and the number of such requests that were approved and denied;
3. The number of internal appeals and grievances filed by members and by providers and the type of service related to the grievance or appeal, ***the total dollar amount of all denials being appealed,*** the time of resolution, the number of internal appeals and grievances where the initial denial was overturned and the type of service and dollar amount associated with the overturned denials;~~[and]~~
4. ***For each internal appeal or grievance not resolved within sixty (60) calendar days, the name of the provider who filed the unresolved internal appeal or grievance, the dollar amount of the claim that was denied if a denial is being appealed, the reason for the delay in resolving the internal appeal or grievance, the current status of the internal appeal or grievance, and the outcome determination if rendered prior to the filing of the report; and***
5. Any other information required by the department.

(b) The data required in paragraph (a) of this subsection shall be separately reported by provider category, as prescribed by the department, and shall at a minimum include inpatient acute care hospital services, inpatient psychiatric hospital services, outpatient hospital services, residential behavioral health

services, and outpatient behavioral health services.

(4) On a monthly basis, the department shall transmit to the Department of Insurance a report of each corrective action plan, fine, or sanction assessed against a Medicaid managed care organization for violation of a Medicaid managed care organization's contract relating to prompt payment of claims. The Department of Insurance shall then make a determination of whether the contract violation was also a violation of KRS 304.17A-700 to 304.17A-730.

(5) ***By December 15 of each year beginning in 2025, the Department for Medicaid Services shall submit to the Legislative Research Commission for referral to the Interim Joint Committee on Health Services and the Legislative Oversight and Investigations Committee a report containing the following information reported separately for each managed care organization with whom the department has contracted for the delivery of Medicaid services:***

(a) The number and dollar value of all claims that were received by the managed care organization and the number of dollar value of those claims that were approved for payment, denied, or suspended;

(b) The number of requests for authorization of services received and the number of those requests that were approved or denied;

(c) The number of internal appeals and grievances filed by Medicaid members and by providers, the types of services to which the internal appeals and grievances relate, the total dollar amount of denials that were appealed, the average length of time to resolution, the number of internal appeals and grievances where the initial denial was overturned, and the types of services and dollar amount of overturned denials; and

(d) The number of internal appeals and grievances not resolved within sixty (60) calendar days, the ten (10) most common reasons given for delays, the total dollar amount when a denial is being appealed, and the number of

final determinations made in favor of a provider.

(6) Any Medicaid managed care organization that fails to comply with ***subsection (1)(d)2. of this section,*** KRS 205.522, 205.532 to 205.536, and 304.17A-515 may be subject to fines, penalties, and sanctions, up to and including termination, as established under its Medicaid managed care contract with the department.

(7) The Department for Medicaid Services may promulgate administrative regulations in accordance with KRS Chapter 13A to implement and enforce this section.

➔Section 7. KRS 304.38-130 is amended to read as follows:

(1) The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this subtitle if the commissioner finds that any of the conditions exist for which the commissioner could suspend or revoke a certificate of authority as provided in Subtitles 2 and 3 of this chapter or if the commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under KRS 304.38-040, unless amendments to such submissions have been filed with and approved by the commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of KRS 304.38-050 or Subtitle 17A of this chapter;

(c) The health maintenance organization does not provide or arrange for health care services as approved by the commissioner in KRS 304.38-050(1)(a);

(d) The certificate of need and licensure board certifies to the commissioner that the health maintenance organization fails to meet the requirements of the board or that the health maintenance organization is unable to fulfill its

obligations to furnish health care services;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(g) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(h) The health maintenance organization has otherwise failed to substantially comply with this subtitle; or

(i) The health maintenance organization has contracted with the Department for Medicaid Services to act as a managed care organization providing Medicaid benefits pursuant to KRS Chapter 205 and has exhibited willful or frequent and repeated failure to comply with**:**~~[KRS 304.17A-700 to 304.17A-730, 205.593, and 304.14-135 and KRS 205.522, 205.532 to 205.536, and 304.17A-515]~~

1. Section 4 of this Act;

2. KRS 205.532 to 205.536;

3. KRS 205.593;

4. Section 1 of this Act;

5. KRS 304.14-135;

6. KRS 304.17A-515;

7. KRS 304.17A-700 to 304.17A-730;

8. 42 U.S.C. sec. 1396u-2; or

9. 42 C.F.R. pt. 438, subpart K.

(2) If the certificate of authority of a health maintenance organization is suspended, the

health maintenance organization shall not, during the period of the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(3) If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit the further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage. If the commissioner permits such further operation the health maintenance organization will continue to collect the periodic prepayments required of enrollees.

➔SECTION 8. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

The Department for Medicaid Services and any managed care organization with whom the department contracts for the delivery of Medicaid services shall provide coverage for evaluation and management services. Coverage required under this section shall not be limited to less than two (2) evaluation and management service units per physician, per recipient, per date of service.

➔Section 9. If the Department for Medicaid Services or the Cabinet for Health and Family Services determines that a state plan amendment, waiver, or any other form of authorization or approval from any federal agency is necessary prior to implementation of Sections 1 to 8 of this Act for any reason, including the loss of federal funds, the department or cabinet shall, within 90 days after the effective date of this Act, request

any necessary state plan amendment, waiver, authorization, or approval, and may only delay full implementation of those provisions for which a state plan amendment, waiver, authorization, or approval was deemed necessary until the state plan amendment, waiver, authorization, or approval is granted or approved.

➔Section 10. The Department for Medicaid Services or the Cabinet for Health and Family Services shall, in accordance with KRS 205.525, provide a copy of any state plan amendment, waiver application, or other request for authorization or approval submitted pursuant to Section 9 of this Act to the Legislative Research Commission for referral to the Interim Joint Committee on Health Services and the Interim Joint Committee on Appropriations and Revenue and shall provide an update on the status of any application or request submitted pursuant to Section 9 of this Act at the request of the Legislative Research Commission or any committee thereof.