AN ACT relating to third-party payors.

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) "Third-party payor":

1. Means an insurer, carrier, limited health service organization, government program, company, self-insured health plan, or any other entity that:

a. Either:

i. Provides any insurance or health plan that is intended to provide coverage or compensation for expenses incurred by a beneficiary; or

ii. Is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service furnished to a beneficiary; and

b. May have an obligation to provide coverage or compensation to a Medicaid-eligible or Medicaid-participating beneficiary for a health care item or service prior to the Medicaid program's payor of last resort benefits for the item or service; and

2. Includes a health insurer or administrator as defined under KRS Chapter 304; and

(b) "Beneficiary" means a beneficiary of the insurance, health plan, or payment obligation provided by a third-party payor.

(2) Pursuant to 42 U.S.C. 1396a(a)(25)(I):

(a) If a third-party payor requires prior authorization for a health care item or service furnished to a Medicaid-eligible or Medicaid-participating

beneficiary, the third-party payor shall:

1. Accept a prior authorization issued by or under the Department for Medicaid Services, any managed care organization contracted to provide Medicaid benefits pursuant to this chapter, or the state's medical assistance program as if the prior authorization was issued by the third-party payor; and

2. Not deny any claim for payment of the health care item or service for failure to obtain prior authorization if the item or service received a prior authorization issued by or under the Department for Medicaid Services, any managed care organization contracted to provide Medicaid benefits pursuant to this chapter, or the state's medical assistance program; and

(b) A third-party payor shall comply with the requirements applicable to third-party payors under Section 2 of this Act.

➔Section 2. KRS 205.623 is amended to read as follows:

(1) ***(a)*** All health insurers and administrators as defined under KRS Chapter 304 shall provide upon request to the Department for Medicaid Services, by electronic means and in the format prescribed by the department, policy and coverage information and claims paid data on Medicaid-eligible policyholders and dependents.

(b) Any request from the department shall include a list of data elements that shall be included on the electronic file from the insurer or administrator.

(2) ***(a)*** All health insurers and administrators as defined under KRS Chapter 304 shall provide upon request to the Department ***for Medicaid Services***, by electronic means and in the format prescribed by the department, identifying information on all policyholders and dependents to match with the Medicaid management information system to determine which policyholders and dependents also

participate in the Kentucky Medical Assistance Program.

(b) The identifying information shall include the name, address, date of birth, and Social Security number as these items appear in the companies' files and as the department may require.

(3) ***(a) As used in this subsection:***

1. "Health care claim" means a claim for payment of a health care item or service; and

2. "Third-party payor" has the same meaning as in Section 1 of this Act.

(b) A third-party payor shall respond within sixty (60) days of receiving an inquiry from the Department for Medicaid Services regarding a health care claim that was submitted within three (3) years of the date of the provision of the item or service.

(4) No health insurer or administrator shall be required to provide information under ***subsection (1) or (2) of*** this section if doing so would violate any ***relevant*** provision of federal law.

(5)~~[(4)]~~ All information obtained by the department pursuant to this section shall be confidential and shall not be open for public inspection.

(6)~~[(5)]~~ The department shall not be charged a fee~~[by a third party]~~ for information requested under this section, nor shall the department be charged a fee~~[by a third party]~~ for the processing and adjudication of the department's claim for recovery, reclamation, or validation of eligibility.

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 18A IS CREATED TO READ AS FOLLOWS:

Any fully insured health benefit plan, self-insured plan, or other health insurance policy, certificate, plan, or contract, or insurer, state cabinet, agency, or official, or third-party administrator, that offers, issues, renews, or provides health insurance coverage to public employees under KRS 18A.225, 18A.2254, or any other section of

this chapter shall comply with the requirements applicable to third-party payors under Sections 1 and 2 of this Act.

➔Section 4. KRS 205.532 is amended to read as follows:

(1) As used in KRS 205.532 to 205.536:

(a) "Clean application" means:

1. For credentialing purposes, a credentialing application submitted by a provider to a credentialing verification organization that:

a. Is complete and correct;

b. Does not lack any required substantiating documentation; and

c. Is consistent with the requirements for the National Committee for Quality Assurance requirements; or

2. For enrollment purposes, an enrollment application submitted by a provider to the department that:

a. Is complete and correct;

b. Does not lack any required substantiating documentation;

c. Complies with all provider screening requirements pursuant to 42 C.F.R. pt. 455; and

d. Is on behalf of a provider who does not have accounts receivable with the department;

(b) "Credentialing alliance" means a contractual agreement entered into by Medicaid managed care organizations under which the managed care organizations agree to utilize a single credentialing verification organization and an identical credentialing process for the purpose of ensuring the timely and efficient credentialing of providers;

(c) "Credentialing application date" means the date that a credentialing verification organization receives a clean application from a provider;

(d) "Credentialing verification organization" means an organization that gathers

data and verifies the credentials of providers in a manner consistent with federal and state laws and the requirements of the National Committee for Quality Assurance;

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

(f) "Medicaid managed care organization" or "managed care organization" means an entity with which the department has contracted to serve as a managed care organization as defined in 42 C.F.R. sec. 438.2;

(g) "Provider" has the same meaning as in KRS 304.17A-700; and

(h) "Request for proposals" has the same meaning as in KRS 45A.070.

(2) Every contract entered into or renewed on or after ***the effective date of this Act***~~[June 29, 2023]~~, for the delivery of Medicaid services by a managed care organization shall:

(a) Be in compliance with KRS 205.522 and 205.532 to 205.536;~~[and]~~

(b) Require participation in a credentialing alliance recognized by the department pursuant to subsection (4) of this section if such an alliance has been established or utilization of the credentialing organization designated by the department pursuant to subsection (5) of this section***; and***

(c) Require the managed care organization to:

1. Require any health care payor entity that the organization operates or controls within this state to comply with the requirements applicable to third-party payors under Sections 1 and 2 of this Act; and

2. Use all reasonable efforts to require entities or businesses with which the organization is associated as part of the organization's managed care operations to comply with the requirements applicable to third-party payors under Sections 1 and 2 of this Act.

(3) The department shall enroll a provider within sixty (60) calendar days of receipt of a clean provider enrollment application. The date of enrollment shall be the date

that the provider's clean application was initially received by the department. The time limits established in this section shall be tolled or paused for any delay caused by an external entity. Tolling events include but are not limited to the screening requirements contained in 42 C.F.R. pt. 455 and searches of federal databases maintained by entities such as the United States Centers for Medicare and Medicaid Services.

(4) (a) The department shall formally recognize a credentialing alliance formed by managed care organizations if:

1. One hundred percent (100%) of the total number of managed care organizations have entered into a contractual agreement to form the credentialing alliance prior to December 1, 2023;
2. The credentialing verification organization contracted as part of the credentialing alliance is accredited by the National Committee for Quality Assurance; and
3. The credentialing verification organization contracted as part of the credentialing organization is owned by or affiliated with a statewide healthcare trade association.

(b) A credentialing alliance established pursuant to this section shall:

1. Implement a single credentialing application via a web-based portal available to all providers seeking to be credentialed for any Medicaid managed care organization that participates in the credentialing alliance;
2. Perform primary source verification and credentialing committee review of each credentialing application that results in a recommendation on the provider's credentialing within thirty (30) days of receipt of a clean application;
3. Notify providers within five (5) business days of receipt of a credentialing application if the application is incomplete;

4. Provide provider outreach and help desk services during common business hours to facilitate provider applications and credentialing information;

5. Expeditiously communicate the credentialing recommendation and supporting credentialing information electronically to the department and to each participating Medicaid managed care organization with which the provider is seeking credentialing; and

6. Conduct reevaluation of provider documentation when required pursuant to state or federal law or when necessary for the provider to maintain participation status with a Medicaid managed care organization.

(5) (a) If a credentialing alliance has not been established and recognized by the department pursuant to subsection (4) of this section by December 31, 2023, the department shall, through a request for proposals and in accordance with KRS Chapter 45A, designate a single credentialing verification organization to verify the credentials of providers on behalf of all managed care organizations.

(b) If the department designates a single credentialing verification organization pursuant to this subsection:

1. The contract between the department and the credentialing verification organization shall be submitted to the Government Contract Review Committee of the Legislative Research Commission for comment and review;

2. The credentialing verification organization shall be reimbursed on a per provider credentialing basis by the department with the reimbursement being offset or deducted equally from each managed care organizations capitation payment;

3. The credentialing verification organization shall comply with paragraph (b) of subsection (4) of this section; and

4. The department may promulgate administrative regulations in accordance with KRS Chapter 13A to ensure the timely and efficient credentialing of providers.

(6) If a Medicaid managed care organization assumes responsibility and costs for their own provider credentialing by entering into a credentialing alliance pursuant to this section, the timely credentialing of providers shall be given significant weight as a factor in the scoring process when the department evaluates the Medicaid managed care organization's response to requests for proposals for all contract awards.

(7) A Medicaid managed care organization shall:

(a) Determine whether it will contract with the provider within thirty (30) calendar days of receipt of the verified credentialing information from a credentialing verification organization either designated by the department or contracted by managed care organizations as part of a credentialing alliance; and

(b) 1. Within ten (10) days of an executed contract, ensure that any internal processing systems of the managed care organization have been updated to include:

a. The accepted provider contract; and

b. The provider as a participating provider.

2. In the event that the loading and configuration of a contract with a provider will take longer than ten (10) days, the managed care organization may take an additional fifteen (15) days if it has notified the provider of the need for additional time.

(8) (a) Nothing in this section requires a Medicaid managed care organization to contract with a provider if the managed care organization and the provider do

not agree on the terms and conditions for participation.

(b) Nothing in this section shall prohibit a provider and a managed care organization from negotiating the terms of a contract prior to the completion of the department's enrollment and screening process.

(9) (a) For the purpose of reimbursement of claims, once a provider has met the terms and conditions for credentialing and enrollment, the provider's credentialing application date shall be the date from which the provider's claims become eligible for payment.

(b) A Medicaid managed care organization shall not require a provider to appeal or resubmit any clean claim submitted during the time period between the provider's credentialing application date and the completion of the credentialing process.

(c) Nothing in this section shall limit the department's authority to establish criteria that allow a provider's claims to become eligible for payment in the event of lifesaving or life-preserving medical treatment, such as, for an illustrative but not exclusive example, an organ transplant.

(10) Nothing in this section shall prohibit a university hospital, as defined in KRS 205.639, from performing the activities of a credentialing verification organization for its employed physicians, residents, and mid-level practitioners where such activities are delineated in the hospital's contract with a Medicaid managed care organization. The provisions of subsections (3), (4), (8), and (9) of this section with regard to payment and timely action on a credentialing application shall apply to a credentialing application that has been verified through a university hospital pursuant to this subsection.

(11) To promote seamless integration of licensure information, the relevant provider licensing boards in Kentucky are encouraged to forward and provide licensure information electronically to the department and any credentialing verification

organization.

➔Section 5. KRS 304.12-255 is amended to read as follows:

(1) As used in this section, "health insurer or administrator as defined under KRS Chapter 304" includes:

(a) 1. An insurer that issues or renews, or an administrator that administers, a health benefit plan.

2. As used in this paragraph, "insurer" and "health benefit plan" have the same meanings as in KRS 304.17A-005;

(b) 1. An insurer that issues or renews, or an administrator that administers, a limited health service benefit plan.

2. As used in this paragraph, "insurer" and "limited health service benefit plan" have the same meanings as in KRS 304.17C-010; and

(c) 1. A limited health service organization that issues or renews, or an administrator that administers, a limited health service contract.

2. As used in this paragraph, "limited health service organization" and "limited health service contract" have the same meanings as in KRS 304.38A-010.

(2) It shall be an unfair or deceptive trade practice for any health insurer or administrator as defined under KRS Chapter 304 to refuse to provide information requested by the Department for Medicaid Services under KRS 205.623***(1) or (2)***, except when providing the requested information would violate any ***relevant*** provision of federal law.

(3) A health insurer or administrator as defined under KRS Chapter 304 shall comply with the requirements applicable to third-party payors under Sections 1 and 2 of this Act.