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) day 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 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]~~

a. Section 4 of this Act;

b. KRS 205.532 to 205.536;

c. KRS 205.593;

d. Section 1 of this Act;

e. KRS 304.14-135;

f. KRS 304.17A-515;

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

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

i. 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.