AN ACT relating to health care provider credentialing.

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

➔SECTION 1. A NEW SECTION OF SUBTITLE 12 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Credentialing" means evaluating and reevaluating a health care provider to be a participating provider under one (1) or more managed care plans;

(b) "Health care provider" or "provider" has the same meaning as in KRS 304.17A-005, except for purposes of this section the term includes any psychologist licensed under KRS Chapter 319;

(c) "Insurer":

1. Means any insurer, self-insurer, self-insured plan, or self-insured group; and

2. Includes:

a. Any health maintenance organization, provider-sponsored integrated delivery network, or nonprofit hospital, medical-surgical, dental, and health service corporation; and

b. Any agent or designee of an insurer;

(d) "Managed care plan" means any health insurance policy, plan, certificate, or contract that integrates the financing and delivery of appropriate health services to insureds by:

1. Making arrangements with participating providers who are selected to participate on the basis of explicit standards to furnish a comprehensive set of health services; and

2. Providing financial incentives for insureds to use the participating providers and procedures provided for in the plan; and

(e) "Uniform application for credentialing" means the most recent version of

the Council for Affordable Quality Healthcare credentialing form.

(2) Each insurer that offers or provides a managed care plan shall:

(a) Have a process for credentialing, with written policies and procedures for review and approval used by the plan, that complies with subsection (3) of this section;

(b) Demonstrate that it has consulted with appropriately qualified health care providers to establish the minimum professional requirements required under subsection (3)(d) of this section;

(c) Establish mechanisms for soliciting and acting upon applications from health care providers to become participating providers in the plan in a fair and systemic manner that comply with subsection (4) of this section; and

(d) Not use a participating health care provider beyond, or outside of, the provider's legally authorized scope of practice.

(3) The process, policies, and procedures required under this section shall:

(a) Require applicants seeking to become participating providers in the plan to complete, and submit to the insurer, the uniform application for credentialing for use by the insurer in making credentialing determinations, except an insurer shall not require an applicant to complete any portion of the uniform application for credentialing that requires or requests the disclosure of any information relating to:

1. A past health condition; or

2. A current health condition if:

a. The health care provider is being treated so that the condition does not affect the provider's ability to provide health care; or

b. The condition would not affect the health care provider's ability to provide health care in a competent, safe, and ethical manner;

(b) Not require or otherwise request participating providers, or applicants

seeking to become participating providers in the plan, to disclose any information that is not required or otherwise requested in accordance with paragraph (a) of this subsection;

(c) Include verification of each health care provider's:

1. License;

2. History of license suspension or revocation; and

3. Liability claims history;

(d) Establish minimum professional requirements for participating health care providers, which:

1. Shall:

a. Be relevant, objective, and reasonably related to the services to be provided; and

b. If the requirements are based on the economics or capacity of a provider's practice, be adjusted to account for:

i. Case mix;

ii. Severity of illness;

iii. Patient age; and

iv.. Any other features that may account for higher-than or lower-than expected costs; and

2. Do not:

a. Allow the insurer to avoid high-risk populations by excluding health care providers because they are located in geographic areas that contain populations or providers presenting a risk of higher-than-average claims, losses, or health service utilization;

b. Exclude a health care provider because the provider treats or specializes in treating populations presenting a risk of higher-than-average claims, losses, or health service utilization;

c. Require a health care provider to be board certified; or

d. Discriminate against a health care provider solely on the basis of the type of license the provider holds in this state;

(e) Establish a written, ongoing process for the reevaluation of each participating provider within a specified number of years after the provider's initial acceptance into the plan, which includes an:

1. Update of the previous review criteria; and

2. Assessment of the health care provider's performance pattern based on criteria such as:

a. Insured clinical outcomes;

b. Number of complaints; and

c. Malpractice actions;

(f) Establish a policy for the removal of or withdrawal by health care providers from the participating provider network that requires:

1. The insurer to notify a participating provider of the insurer's removal and withdrawal policy:

a. At the time the insurer contracts with the provider to be a participating provider; and

b. When changes are made to the policy;

2. The insurer and participating providers to comply with the standards in 42 U.S.C. sec. 11112 if a provider's participation will be terminated or withdrawn prior to the contract termination date as a result of a professional review action;

3. The insurer's medical director to promptly notify the appropriate professional state licensing board if the insurer finds that a health care provider represents an imminent danger to an insured or to the public health, safety, or welfare; and

4. The insurer to:

a. Notify the insured; and

b. Arrange for the insured's continuity of care with an approved primary care provider;

if the insurer terminates the participation of an insured's primary care provider; and

(g) Comply with the guidelines established by the commissioner under subsection (5) of this section.

(4) (a) The mechanisms required under subsection (2)(c) of this section shall, at a minimum:

1. Allow all providers seeking to become participating providers in the plan an opportunity to apply:

a. At any time during the year, except as provided in subdivision b. of this subparagraph; or

b. If an insurer does not conduct open continuous provider enrollment, at least annually during a provider open enrollment period with the date publicized to providers located in the geographic service area of the plan at least thirty (30) days prior to the enrollment period;

2. Provide applicants with notice of a credentialing determination within forty-five (45) days of receiving a uniform application for credentialing that is completed to the extent required under subsection (3)(a) of this section, except as provided in paragraph (b) of this subsection; and

3. Make criteria for becoming a participating provider in the plan available to all applicants.

(b) Paragraph (a)2. of this subsection shall not apply if the failure to timely

notify an applicant of a credentialing application was due to or results from, in whole or in part, acts or events beyond the control of the insurer, including but not limited to:

1. Acts of God;

2. Natural disasters;

3. Epidemics;

4. Strikes or other labor disruptions;

5. War;

6. Civil disturbances;

7. Riots; or

8. Complete or partial disruptions of facilities.

(5) (a) The commissioner shall promulgate an administrative regulation to establish guidelines for the process of credentialing in accordance with this section.

(b) In developing the guidelines, the commissioner shall consider industry standards and guidelines adopted by the Council for Affordable Quality Healthcare.

(6) (a) Following credentialing and upon a health care provider's signing of a contract with an insurer to provide health services under a managed care plan, the insurer shall make payments to the provider for the services rendered during the credentialing process in accordance with procedures for reimbursement of participating providers under the plan.

(b) If a health care provider's credentialing application to provide health services under a managed care plan is denied and the plan provides out-of-network benefits, the insurer shall make payments to the provider in accordance with procedures for reimbursement of nonparticipating providers under the plan.

➔Section 2. KRS 18A.225 is amended to read as follows:

(1) (a) The term "employee" for purposes of this section means:

1. Any person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567; or is eligible to participate in a retirement plan established by an employer who ceases participating in the Kentucky Employees Retirement System pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Employees Retirement System;
2. Any certified or classified employee of a local board of education or a public charter school as defined in KRS 160.1590;
3. Any elected member of a local board of education;
4. Any person who is a present or future recipient of a retirement allowance from the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the

Legislators' Retirement Plan, the Judicial Retirement Plan, or the Kentucky Community and Technical College System's optional retirement plan authorized by KRS 161.567, except that a person who is receiving a retirement allowance and who is age sixty-five (65) or older shall not be included, with the exception of persons covered under KRS 61.702(2)(b)3. and 78.5536(2)(b)3., unless he or she is actively employed pursuant to subparagraph 1. of this paragraph; and

5. Any eligible dependents and beneficiaries of participating employees and retirees who are entitled to participate in the state-sponsored health insurance program;

(b) The term "health benefit plan" for the purposes of this section means a health benefit plan as defined in KRS 304.17A-005;

(c) The term "insurer" for the purposes of this section means an insurer as defined in KRS 304.17A-005; and

(d) The term "managed care plan" for the purposes of this section means a managed care plan as defined in KRS 304.17A-500.

(2) (a) The secretary of the Finance and Administration Cabinet, upon the recommendation of the secretary of the Personnel Cabinet, shall procure, in compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090, from one (1) or more insurers authorized to do business in this state, a group health benefit plan that may include but not be limited to health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS), and exclusive provider organization (EPO) benefit plans encompassing all or any class or classes of employees. With the exception of employers governed by the provisions of KRS Chapters 16, 18A, and 151B, all employers of any class of employees or former employees shall enter into a contract with the Personnel Cabinet prior to including that group in the state

health insurance group. The contracts shall include but not be limited to designating the entity responsible for filing any federal forms, adoption of policies required for proper plan administration, acceptance of the contractual provisions with health insurance carriers or third-party administrators, and adoption of the payment and reimbursement methods necessary for efficient administration of the health insurance program. Health insurance coverage provided to state employees under this section shall, at a minimum, contain the same benefits as provided under Kentucky Kare Standard as of January 1, 1994, and shall include a mail-order drug option as provided in subsection (13) of this section. All employees and other persons for whom the health care coverage is provided or made available shall annually be given an option to elect health care coverage through a self-funded plan offered by the Commonwealth or, if a self-funded plan is not available, from a list of coverage options determined by the competitive bid process under the provisions of KRS 45A.080, 45A.085, and 45A.090 and made available during annual open enrollment.

(b) The policy or policies shall be approved by the commissioner of insurance and may contain the provisions the commissioner of insurance approves, whether or not otherwise permitted by the insurance laws.

(c) Any carrier bidding to offer health care coverage to employees shall agree to provide coverage to all members of the state group, including active employees and retirees and their eligible covered dependents and beneficiaries, within the county or counties specified in its bid. Except as provided in subsection (20) of this section, any carrier bidding to offer health care coverage to employees shall also agree to rate all employees as a single entity, except for those retirees whose former employers insure their active employees outside the state-sponsored health insurance program and as

otherwise provided in KRS 61.702(2)(b)3.b. and 78.5536(2)(b)3.b.

(d) Any carrier bidding to offer health care coverage to employees shall agree to provide enrollment, claims, and utilization data to the Commonwealth in a format specified by the Personnel Cabinet with the understanding that the data shall be owned by the Commonwealth; to provide data in an electronic form and within a time frame specified by the Personnel Cabinet; and to be subject to penalties for noncompliance with data reporting requirements as specified by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions to protect the confidentiality of each individual employee; however, confidentiality assertions shall not relieve a carrier from the requirement of providing stipulated data to the Commonwealth.

(e) The Personnel Cabinet shall develop the necessary techniques and capabilities for timely analysis of data received from carriers and, to the extent possible, provide in the request-for-proposal specifics relating to data requirements, electronic reporting, and penalties for noncompliance. The Commonwealth shall own the enrollment, claims, and utilization data provided by each carrier and shall develop methods to protect the confidentiality of the individual. The Personnel Cabinet shall include in the October annual report submitted pursuant to the provisions of KRS 18A.226 to the Governor, the General Assembly, and the Chief Justice of the Supreme Court, an analysis of the financial stability of the program, which shall include but not be limited to loss ratios, methods of risk adjustment, measurements of carrier quality of service, prescription coverage and cost management, and statutorily required mandates. If state self-insurance was available as a carrier option, the report also shall provide a detailed financial analysis of the self-insurance fund including but not limited to loss ratios, reserves, and reinsurance agreements.

(f) If any agency participating in the state-sponsored employee health insurance

program for its active employees terminates participation and there is a state appropriation for the employer's contribution for active employees' health insurance coverage, then neither the agency nor the employees shall receive the state-funded contribution after termination from the state-sponsored employee health insurance program.

(g) Any funds in flexible spending accounts that remain after all reimbursements have been processed shall be transferred to the credit of the state-sponsored health insurance plan's appropriation account.

(h) Each entity participating in the state-sponsored health insurance program shall provide an amount at least equal to the state contribution rate for the employer portion of the health insurance premium. For any participating entity that used the state payroll system, the employer contribution amount shall be equal to but not greater than the state contribution rate.

(3) The premiums may be paid by the policyholder:

(a) Wholly from funds contributed by the employee, by payroll deduction or otherwise;

(b) Wholly from funds contributed by any department, board, agency, public postsecondary education institution, or branch of state, city, urban-county, charter county, county, or consolidated local government; or

(c) Partly from each, except that any premium due for health care coverage or dental coverage, if any, in excess of the premium amount contributed by any department, board, agency, postsecondary education institution, or branch of state, city, urban-county, charter county, county, or consolidated local government for any other health care coverage shall be paid by the employee.

(4) If an employee moves his or her place of residence or employment out of the service area of an insurer offering a managed health care plan, under which he or she has elected coverage, into either the service area of another managed health care

plan or into an area of the Commonwealth not within a managed health care plan service area, the employee shall be given an option, at the time of the move or transfer, to change his or her coverage to another health benefit plan.

(5) No payment of premium by any department, board, agency, public postsecondary educational institution, or branch of state, city, urban-county, charter county, county, or consolidated local government shall constitute compensation to an insured employee for the purposes of any statute fixing or limiting the compensation of such an employee. Any premium or other expense incurred by any department, board, agency, public postsecondary educational institution, or branch of state, city, urban-county, charter county, county, or consolidated local government shall be considered a proper cost of administration.

(6) The policy or policies may contain the provisions with respect to the class or classes of employees covered, amounts of insurance or coverage for designated classes or groups of employees, policy options, terms of eligibility, and continuation of insurance or coverage after retirement.

(7) Group rates under this section shall be made available to the disabled child of an employee regardless of the child's age if the entire premium for the disabled child's coverage is paid by the state employee. A child shall be considered disabled if he or she has been determined to be eligible for federal Social Security disability benefits.

(8) The health care contract or contracts for employees shall be entered into for a period of not less than one (1) year.

(9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of State Health Insurance Subscribers to advise the secretary or the secretary's designee regarding the state-sponsored health insurance program for employees. The secretary shall appoint, from a list of names submitted by appointing authorities, members representing school districts from each of the seven (7) Supreme Court districts, members representing state government from each of the

seven (7) Supreme Court districts, two (2) members representing retirees under age sixty-five (65), one (1) member representing local health departments, two (2) members representing the Kentucky Teachers' Retirement System, and three (3) members at large. The secretary shall also appoint two (2) members from a list of five (5) names submitted by the Kentucky Education Association, two (2) members from a list of five (5) names submitted by the largest state employee organization of nonschool state employees, two (2) members from a list of five (5) names submitted by the Kentucky Association of Counties, two (2) members from a list of five (5) names submitted by the Kentucky League of Cities, and two (2) members from a list of names consisting of five (5) names submitted by each state employee organization that has two thousand (2,000) or more members on state payroll deduction. The advisory committee shall be appointed in January of each year and shall meet quarterly.

(10) Notwithstanding any other provision of law to the contrary, the policy or policies provided to employees pursuant to this section shall not provide coverage for obtaining or performing an abortion, nor shall any state funds be used for the purpose of obtaining or performing an abortion on behalf of employees or their dependents.

(11) Interruption of an established treatment regime with maintenance drugs shall be grounds for an insured to appeal a formulary change through the established appeal procedures approved by the Department of Insurance, if the physician supervising the treatment certifies that the change is not in the best interests of the patient.

(12) Any employee who is eligible for and elects to participate in the state health insurance program as a retiree, or the spouse or beneficiary of a retiree, under any one (1) of the state-sponsored retirement systems shall not be eligible to receive the state health insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not

preclude a retiree and an active employee spouse from using both contributions to the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year.

(13) (a) The policies of health insurance coverage procured under subsection (2) of this section shall include a mail-order drug option for maintenance drugs for state employees. Maintenance drugs may be dispensed by mail order in accordance with Kentucky law.

(b) A health insurer shall not discriminate against any retail pharmacy located within the geographic coverage area of the health benefit plan and that meets the terms and conditions for participation established by the insurer, including price, dispensing fee, and copay requirements of a mail-order option. The retail pharmacy shall not be required to dispense by mail.

(c) The mail-order option shall not permit the dispensing of a controlled substance classified in Schedule II.

(14) The policy or policies provided to state employees or their dependents pursuant to this section shall provide coverage for obtaining a hearing aid and acquiring hearing aid-related services for insured individuals under eighteen (18) years of age, subject to a cap of one thousand four hundred dollars ($1,400) every thirty-six (36) months pursuant to KRS 304.17A-132.

(15) Any policy provided to state employees or their dependents pursuant to this section shall provide coverage for the diagnosis and treatment of autism spectrum disorders consistent with KRS 304.17A-142.

(16) Any policy provided to state employees or their dependents pursuant to this section shall provide coverage for obtaining amino acid-based elemental formula pursuant to KRS 304.17A-258.

(17) If a state employee's residence and place of employment are in the same county, and if the hospital located within that county does not offer surgical services,

intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services, and magnetic resonance imaging services, the employee may select a plan available in a contiguous county that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.

(18) If a state employee's residence and place of employment are each located in counties in which the hospitals do not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services, and magnetic resonance imaging services, the employee may select a plan available in a county contiguous to the county of residence that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.

(19) The Personnel Cabinet is encouraged to study whether it is fair and reasonable and in the best interests of the state group to allow any carrier bidding to offer health care coverage under this section to submit bids that may vary county by county or by larger geographic areas.

(20) Notwithstanding any other provision of this section, the bid for proposals for health insurance coverage for calendar year 2004 shall include a bid scenario that reflects the statewide rating structure provided in calendar year 2003 and a bid scenario that allows for a regional rating structure that allows carriers to submit bids that may vary by region for a given product offering as described in this subsection:

(a) The regional rating bid scenario shall not include a request for bid on a statewide option;

(b) The Personnel Cabinet shall divide the state into geographical regions which shall be the same as the partnership regions designated by the Department for Medicaid Services for purposes of the Kentucky Health Care Partnership Program established pursuant to 907 KAR 1:705;

(c) The request for proposal shall require a carrier's bid to include every county within the region or regions for which the bid is submitted and include but not be restricted to a preferred provider organization (PPO) option;

(d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the carrier all of the counties included in its bid within the region. If the Personnel Cabinet deems the bids submitted in accordance with this subsection to be in the best interests of state employees in a region, the cabinet may award the contract for that region to no more than two (2) carriers; and

(e) Nothing in this subsection shall prohibit the Personnel Cabinet from including other requirements or criteria in the request for proposal.

(21) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 12, 2006, to public employees pursuant to this section which provides coverage for services rendered by a physician or osteopath duly licensed under KRS Chapter 311 that are within the scope of practice of an optometrist duly licensed under the provisions of KRS Chapter 320 shall provide the same payment of coverage to optometrists as allowed for those services rendered by physicians or osteopaths.

(22) Any fully insured health benefit plan or self-insured plan issued or renewed to public employees pursuant to this section shall comply with:

(a) KRS 304.12-237;

(b) KRS 304.17A-270~~[and 304.17A-525]~~;

(c) KRS 304.17A-600 to 304.17A-633;

(d) KRS 205.593;

(e) KRS 304.17A-700 to 304.17A-730;

(f) KRS 304.14-135;

(g) KRS 304.17A-580 and 304.17A-641;

(h) KRS 304.99-123;

(i) KRS 304.17A-138;

(j) KRS 304.17A-148;

(k) KRS 304.17A-163 and 304.17A-1631;

(l) KRS 304.17A-265;

(m) KRS 304.17A-261;

(n) KRS 304.17A-262;

(o) KRS 304.17A-145;

(p) KRS 304.17A-129;

(q) KRS 304.17A-133;

(r) KRS 304.17A-264;~~[and]~~

(s) ***Section 1 of this Act; and***

(t) Administrative regulations promulgated pursuant to statutes listed in this subsection.

(23) (a) Any fully insured health benefit plan or self-insured plan issued or renewed to public employees pursuant to this section shall provide a special enrollment period to pregnant women who are eligible for coverage in accordance with the requirements set forth in KRS 304.17-182.

(b) The Department of Employee Insurance shall, at or before the time a public employee is initially offered the opportunity to enroll in the plan or coverage, provide the employee a notice of the special enrollment rights under this subsection.

➔Section 3. KRS 205.560 is amended to read as follows:

(1) The scope of medical care for which the Cabinet for Health and Family Services undertakes to pay shall be designated and limited by regulations promulgated by the cabinet, pursuant to the provisions in this section. Within the limitations of any appropriation therefor, the provision of complete upper and lower dentures to recipients of Medical Assistance Program benefits who have their teeth removed by

a dentist resulting in the total absence of teeth shall be a mandatory class in the scope of medical care. Payment to a dentist of any Medical Assistance Program benefits for complete upper and lower dentures shall only be provided on the condition of a preauthorized agreement between an authorized representative of the Medical Assistance Program and the dentist prior to the removal of the teeth. The selection of another class or other classes of medical care shall be recommended by the council to the secretary for health and family services after taking into consideration, among other things, the amount of federal and state funds available, the most essential needs of recipients, and the meeting of such need on a basis insuring the greatest amount of medical care as defined in KRS 205.510 consonant with the funds available, including but not limited to the following categories, except where the aid is for the purpose of obtaining an abortion:

(a) Hospital care, including drugs, and medical supplies and services during any period of actual hospitalization;

(b) Nursing-home care, including medical supplies and services, and drugs during confinement therein on prescription of a physician, dentist, or podiatrist;

(c) Drugs, nursing care, medical supplies, and services during the time when a recipient is not in a hospital but is under treatment and on the prescription of a physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall include products for the treatment of inborn errors of metabolism or genetic, gastrointestinal, and food allergic conditions, consisting of therapeutic food, formulas, supplements, amino acid-based elemental formula, or low-protein modified food products that are medically indicated for therapeutic treatment and are administered under the direction of a physician, and include but are not limited to the following conditions:

1. Phenylketonuria;

2. Hyperphenylalaninemia;

3. Tyrosinemia (types I, II, and III);
4. Maple syrup urine disease;
5. A-ketoacid dehydrogenase deficiency;
6. Isovaleryl-CoA dehydrogenase deficiency;
7. 3-methylcrotonyl-CoA carboxylase deficiency;
8. 3-methylglutaconyl-CoA hydratase deficiency;
9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency);
10. B-ketothiolase deficiency;
11. Homocystinuria;
12. Glutaric aciduria (types I and II);
13. Lysinuric protein intolerance;
14. Non-ketotic hyperglycinemia;
15. Propionic acidemia;
16. Gyrate atrophy;
17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
18. Carbamoyl phosphate synthetase deficiency;
19. Ornithine carbamoyl transferase deficiency;
20. Citrullinemia;
21. Arginosuccinic aciduria;
22. Methylmalonic acidemia;
23. Argininemia;
24. Food protein allergies;
25. Food protein-induced enterocolitis syndrome;
26. Eosinophilic disorders; and
27. Short bowel syndrome;

(d) Physician, podiatric, and dental services;

(e) Optometric services for all age groups shall be limited to prescription services, services to frames and lenses, and diagnostic services provided by an optometrist, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses shall be provided only to children under age twenty-one (21);

(f) Drugs on the prescription of a physician used to prevent the rejection of transplanted organs if the patient is indigent; and

(g) Nonprofit neighborhood health organizations or clinics where some or all of the medical services are provided by licensed registered nurses or by advanced medical students presently enrolled in a medical school accredited by the Association of American Medical Colleges and where the students or licensed registered nurses are under the direct supervision of a licensed physician who rotates his services in this supervisory capacity between two (2) or more of the nonprofit neighborhood health organizations or clinics specified in this paragraph.

(2) Payments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies. It shall be one (1) of the functions of the council to make recommendations to the Cabinet for Health and Family Services with respect to the bases for payment. In determining the rates of reimbursement for long-term-care facilities participating in the Medical Assistance Program, the Cabinet for Health and Family Services shall, to the extent permitted by federal law, not allow the following items to be considered as a cost to the facility for purposes of reimbursement:

(a) Motor vehicles that are not owned by the facility, including motor vehicles that are registered or owned by the facility but used primarily by the owner or

family members thereof;

(b) The cost of motor vehicles, including vans or trucks, used for facility business shall be allowed up to fifteen thousand dollars ($15,000) per facility, adjusted annually for inflation according to the increase in the consumer price index-u for the most recent twelve (12) month period, as determined by the United States Department of Labor. Medically equipped motor vehicles, vans, or trucks shall be exempt from the fifteen thousand dollar ($15,000) limitation. Costs exceeding this limit shall not be reimbursable and shall be borne by the facility. Costs for additional motor vehicles, not to exceed a total of three (3) per facility, may be approved by the Cabinet for Health and Family Services if the facility demonstrates that each additional vehicle is necessary for the operation of the facility as required by regulations of the cabinet;

(c) Salaries paid to immediate family members of the owner or administrator, or both, of a facility, to the extent that services are not actually performed and are not a necessary function as required by regulation of the cabinet for the operation of the facility. The facility shall keep a record of all work actually performed by family members;

(d) The cost of contracts, loans, or other payments made by the facility to owners, administrators, or both, unless the payments are for services which would otherwise be necessary to the operation of the facility and the services are required by regulations of the Cabinet for Health and Family Services. Any other payments shall be deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health and Family Services. Interest paid to the facility for loans made to a third party may be used to offset allowable interest claimed by the facility;

(e) Private club memberships for owners or administrators, travel expenses for trips outside the state for owners or administrators, and other indirect

payments made to the owner, unless the payments are deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health and Family Services; and

(f) Payments made to related organizations supplying the facility with goods or services shall be limited to the actual cost of the goods or services to the related organization, unless it can be demonstrated that no relationship between the facility and the supplier exists. A relationship shall be considered to exist when an individual, including brothers, sisters, father, mother, aunts, uncles, and in-laws, possesses a total of five percent (5%) or more of ownership equity in the facility and the supplying business. An exception to the relationship shall exist if fifty-one percent (51%) or more of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations.

(3) No vendor payment shall be made unless the class and type of medical care rendered and the cost basis therefor has first been designated by regulation.

(4) The rules and regulations of the Cabinet for Health and Family Services shall require that a written statement, including the required opinion of a physician, shall accompany any claim for reimbursement for induced premature births. This statement shall indicate the procedures used in providing the medical services.

(5) The range of medical care benefit standards provided and the quality and quantity standards and the methods for determining cost formulae for vendor payments within each category of public assistance and other recipients shall be uniform for the entire state, and shall be designated by regulation promulgated within the limitations established by the Social Security Act and federal regulations. It shall not be necessary that the amount of payments for units of services be uniform for the entire state but amounts may vary from county to county and from city to city, as well as among hospitals, based on the prevailing cost of medical care in each

locale and other local economic and geographic conditions, except that insofar as allowed by applicable federal law and regulation, the maximum amounts reimbursable for similar services rendered by physicians within the same specialty of medical practice shall not vary according to the physician's place of residence or place of practice, as long as the place of practice is within the boundaries of the state.

(6) Nothing in this section shall be deemed to deprive a woman of all appropriate medical care necessary to prevent her physical death.

(7) To the extent permitted by federal law, no medical assistance recipient shall be recertified as qualifying for a level of long-term care below the recipient's current level, unless the recertification includes a physical examination conducted by a physician licensed pursuant to KRS Chapter 311 or by an advanced practice registered nurse licensed pursuant to KRS Chapter 314 and acting under the physician's supervision.

(8) (a) If payments made to community mental health centers, established pursuant to KRS Chapter 210, for services provided to the intellectually disabled exceed the actual cost of providing the service, the balance of the payments shall be used solely for the provision of other services to the intellectually disabled through community mental health centers.

(b) Except as provided in KRS 210.370(4) and (5)(c), if a community mental health center, established pursuant to KRS Chapter 210, provides services to a recipient of Medical Assistance Program benefits outside of the community mental health center's regional service area, as established in KRS 210.370, the community mental health center shall not be reimbursed for such services in accordance with the department's fee schedule for community mental health centers but shall instead be reimbursed in accordance with the department's fee schedule for behavioral health service organizations.

(c) As used in this subsection, "community mental health center" means a regional community services program as defined in KRS 210.005.

(9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to recipients of medical assistance under Title XIX of the Social Security Act on July 15, 1986, shall deny admission of a person to a bed certified for reimbursement under the provisions of the Medical Assistance Program solely on the basis of the person's paying status as a Medicaid recipient. No person shall be removed or discharged from any facility solely because they became eligible for participation in the Medical Assistance Program, unless the facility can demonstrate the resident or the resident's responsible party was fully notified in writing that the resident was being admitted to a bed not certified for Medicaid reimbursement. No facility may decertify a bed occupied by a Medicaid recipient or may decertify a bed that is occupied by a resident who has made application for medical assistance.

(10) Family-practice physicians practicing in geographic areas with no more than one (1) primary-care physician per five thousand (5,000) population, as reported by the United States Department of Health and Human Services, shall be reimbursed one hundred twenty-five percent (125%) of the standard reimbursement rate for physician services.

(11) The Cabinet for Health and Family Services shall make payments under the Medical Assistance Program for services which are within the lawful scope of practice of a chiropractor licensed pursuant to KRS Chapter 312, to the extent the Medical Assistance Program pays for the same services provided by a physician.

(12) (a) ***1.*** The Medical Assistance Program shall use the appropriate form and guidelines for enrolling those providers applying for participation in the Medical Assistance Program, including those licensed and regulated under KRS Chapters 311, 312, 314, 315, and 320, any facility required to be licensed pursuant to KRS Chapter 216B, and any other health care

practitioner or facility as determined by the Department for Medicaid Services through an administrative regulation promulgated under KRS Chapter 13A.

2. ***To credential a provider,*** a Medicaid managed care organization shall use the***:***

a. Uniform application for credentialing, as defined in Section 1 of this Act;~~[forms]~~ and

b. Guidelines established ***by the commissioner of the Department of Insurance*** under ***Section 1 of this Act***~~[KRS 304.17A-545(5) to credential a provider]~~.

3. For any provider who contracts with and is credentialed by a Medicaid managed care organization prior to enrollment, the cabinet shall complete the enrollment process and deny, or approve and issue a Provider Identification Number (PID) within fifteen (15) business days from the time all necessary completed enrollment forms have been submitted and all outstanding accounts receivable have been satisfied.

(b) Within forty-five (45) days of receiving a correct and complete provider application, the Department for Medicaid Services shall complete the enrollment process by either denying or approving and issuing a Provider Identification Number (PID) for a behavioral health provider who provides substance use disorder services, unless the department notifies the provider that additional time is needed to render a decision for resolution of an issue or dispute.

(c) Within forty-five (45) days of receipt of a correct and complete application for credentialing by a behavioral health provider providing substance use disorder services, a Medicaid managed care organization shall complete its contracting and credentialing process, unless the Medicaid managed care organization

notifies the provider that additional time is needed to render a decision. If additional time is needed, the Medicaid managed care organization shall not take any longer than ninety (90) days from receipt of the credentialing application to deny or approve and contract with the provider.

(d) A Medicaid managed care organization shall adjudicate any clean claims submitted for a substance use disorder service from an enrolled and credentialed behavioral health provider who provides substance use disorder services in accordance with KRS 304.17A-700 to 304.17A-730.

(e) The Department of Insurance may impose a civil penalty of one hundred dollars ($100) per violation when a Medicaid managed care organization fails to comply with this section. Each day that a Medicaid managed care organization fails to pay a claim may count as a separate violation.

(13) Dentists licensed under KRS Chapter 313 shall be excluded from the requirements of subsection (12) of this section. The Department for Medicaid Services shall develop a specific form and establish guidelines for assessing the credentials of dentists applying for participation in the Medical Assistance Program.

➔Section 4. KRS 216B.155 is amended to read as follows:

(1) ***(a)*** All health care facilities and services licensed under this chapter, with the exception of personal care homes, family care homes, and boarding homes, shall develop comprehensive quality assurance or improvement standards adequate to identify, evaluate, and remedy problems related to the quality of health care facilities and services. These standards shall be made available upon request to the public during regular business hours and shall include:

1. ~~[(a)]~~ An ongoing written internal quality assurance or improvement program;

2. ~~[(b)]~~ Specific, written guidelines for quality care studies and monitoring;

3.~~[(c)]~~ Performance and clinical outcomes-based criteria;

4.~~[(d)]~~ Procedures for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

5.~~[(e)]~~ A plan for data gathering and assessment;

6.~~[(f)]~~ A peer review process; and

7.~~[(g)]~~ A summary of process outcomes and follow-up actions related to the overall quality improvement program for the health care facility or service.

(b) Current federal or state regulations which address quality assurance and quality improvement requirements for nursing facilities, intermediate care facilities, and skilled care facilities shall suffice for compliance with the standards in this section.

(2) ***When assessing the credentials of those applying for privileges,*** all health care facilities licensed ***under this chapter***, with the exception of personal care homes, family care homes, and boarding homes,~~[under this chapter,]~~ shall***:***

(a) Use the***:***

1. Uniform application for credentialing, as defined in Section 1 of this Act, except as provided in paragraph (b) of this subsection; and

2. Guidelines established by the commissioner of the Department of Insurance under Section 1 of this Act; and

(b) Not require or otherwise request the disclosure of any of the following information:

1. A past health condition; or

2. A current health condition if:

a. The provider is being treated so that the condition does not affect the provider's ability to provide health care; or

b. The health condition would not affect the provider's ability to

provide health care in a competent, safe, and ethical manner~~[application form and guidelines established pursuant to KRS 304.17A-545(5) for assessing the credentials of those applying for privileges]~~.

➔Section 5. 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; and

(d) 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:

1. Participating physicians have an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of

the insurer; and

2. 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**:**

1. To respond to authorization requests for urgent services**;** and~~[is available,]~~

2. 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**:**

1. Choose or change a primary care provider from among participating providers in the provider network**;** and~~[,]~~

2. 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.]~~

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

➔Section 6. KRS 311.6207 is amended to read as follows:

Nothing in KRS 311.6204 to 311.6207 shall be construed to:

(1) Allow a physician to withhold information ***that is*** requested by the ***insurer during the process for credentialing in accordance with***~~[current version of the uniform application form for the evaluation and reevaluation of health care providers required]~~ ***Section 1 of this Act***~~[by KRS 304.17A-545]~~; or

(2) Waive a physician's obligation to:

(a) Disclose information regarding any condition for which the physician is not being appropriately treated and that impairs the physician's judgment or adversely affects the physician's ability to practice medicine in a competent, ethical, and professional manner; or

(b) Report information regarding another physician to the Kentucky Board of Medical Licensure under KRS 311.606.

➔Section 7. The following KRS sections are repealed:

304.17A-525 Standards for provider participation -- Mechanisms for consideration of provider applications -- Policy for removal or withdrawal.

304.17A-576 Notice by managed care plan insurer of health care provider's application for credentialing -- Payments to applicant.

➔Section 8. Sections 1 to 5 of this Act apply to contracts issued or renewed on or after the effective date of this Act.

➔Section 9. Within 90 days of the effective date of this Act, the Department for Medicaid Services, the Cabinet for Health and Family Services, the commissioner of the Department of Insurance, and any other administrative body shall amend, as necessary, any administrative regulations, including but not limited to 907 KAR 001:672, 902 KAR 020:008, and 806 KAR 017:480, that conflict with any provision of this Act to eliminate the conflict.