AN ACT relating to service delivery improvements in managed care networks.

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) "Clean application" means an application submitted by a provider to a credentialing verification organization that:

1. Is complete;

2. Has no defect;

3. Has no misstatement of facts; and

4. Does not lack any required substantiating documentation;

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

(c) "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;

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

(e) "Medicaid managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. sec. 438.2; and

(f) "Provider" has the same meaning as in Section 6 of this Act.

(2) On and after the effective date of this Act, every contract entered into or renewed for the delivery of Medicaid services as a managed care organization shall be in compliance with this section and Sections 2, 3, 4, and 5 of this Act.

(3) The Department for Medicaid Services shall designate a single credentialing

verification organization to verify the credentials of providers on behalf of the department and all Medicaid managed care organizations. Following designation pursuant to this subsection, the contract between the department and the designated credentialing verification organization shall be submitted to the Government Contract Review Committee for comment and approval. A designated credentialing verification organization shall be reimbursed by the department for credentialing services, and this expense shall be reduced from Medicaid managed care organization capitation rates. Each provider seeking to be enrolled in Medicaid and credentialed with the department and a Medicaid managed care organization shall submit a single credentialing application to the designated credentialing verification organization. The designated credentialing verification organization shall:

(a) Gather all necessary documentation from each provider;

(b) Within five (5) days of receipt of a credentialing application, notify the provider in writing if the application is complete and has no defect;

(c) Review an application for any misstatement of fact or a lack of substantiating documentation;

(d) Provide verified credentialing packets to the department and to each Medicaid managed care organization as requested by the provider within thirty (30) days of receipt of a clean application; and

(e) Conduct reevaluations of provider documentation when required by state or federal law or for the provider to maintain participation status with the department or a Medicaid managed care organization.

(4) (a) The department shall enroll a provider within fifteen (15) days of receipt of a verified credentialing packet for the provider from a credentialing verification organization. The date of enrollment shall be the date that the provider's application was initially received by a credentialing verification

organization.

(b) The Medicaid managed care organization shall determine whether they will contract with the provider within fifteen (15) calendar days of receipt of the verified credentialing packet from the credentialing verification organization.

(5) Nothing in this section requires a Medicaid managed care organization to contract with a provider if the Medicaid managed care organization and the provider do not agree on the terms and conditions for participation.

(6) Once a provider has met the terms and conditions for credentialing and enrollment, then the date of the provider's credentialing application date shall be deemed to be the date of original enrollment and credentialing for reimbursement of claims purposes. A Medicaid managed care organization shall not require a provider to appeal or resubmit any clean claim submitted during the time elapsing between the provider's credentialing application date and a Medicaid managed care organization's completion of its credentialing process.

(7) Nothing in this section shall prohibit a university hospital as defined under 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; except that a Medicaid managed care organization shall be subject to the provisions of subsections (3), (4), (5), and (6) of this section with regard to payment and timely action and on a credentialing application that has been verified through a university hospital.

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

(1) The written internal appeals process of a Medicaid managed care organization shall include provisions that establish:

(a) Access to a designated contact for prompt claims resolution eight (8) hours per day, seven (7) days each week to resolve matters related to the payment or nonpayment of submitted claims;

(b) Access to in-person telephonic utilization review twenty-four (24) hours each day, seven (7) days each week to receive requests for authorization of covered services;

(c) Within one hundred twenty (120) days of the effective date of this Act, an interactive Web site operated by the managed care organization that allows providers to file grievances, appeals, and documents in support thereof 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; and

(d) Procedures for:

1. Allowing a provider to file any grievance or appeal related to the payment or nonpayment of any claim for services if filed within sixty (60) days of the provider's receipt of a Medicaid managed care organization's notification that payment for any such claim has been reduced or denied;

2. Ensuring the timely consideration and disposition within thirty (30) days from the filing of any grievance and any appeal for a provider related to the payment or nonpayment of any claim for services;

3. Requiring a written reply in detail sufficient to inform the provider of all reasons for any adverse payment or coverage determination, including access at no charge to copies of all documents, records, and other information relevant to the determination, including medical necessity criteria and any processes, strategies, or evidentiary standards relied upon in the adverse payment or coverage

determination;

4. Reprocessing of claims that are incorrectly paid or denied in error. 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

5. Affording each participating provider the opportunity for an in-person meeting with an informed representative of the Medicaid managed care organization on any claim or set of claims that remains unpaid forty-five (45) days or more past the date that the claim is received by the Medicaid managed care organization and that individually or in the aggregate exceed two thousand five hundred dollars ($2,500).

(2) (a) 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 consistent manner such that Medicaid members with comparable medical needs receive a timely, comparable, consistent level, amount, and duration of services as supported by the member's medical condition, records, and previous affirmative coverage decisions.

(b) For the purposes of this subsection:

1. "Timely" means that an authorization or preauthorization request shall be approved within two (2) business days for a request considered to be urgent, and within two (2) business days for a standard authorization or preauthorization request. A standard authorization or preauthorization request may include the opportunity for one (1) extension of time of up to fourteen (14) days if agreed to by the provider or enrollee; and

2. "Urgent" means a request for authorization or preauthorization

where use of the standard authorization or preauthorization request time frame could seriously jeopardize an enrollee's life, health, or ability to attain, maintain, or regain maximum function.

(c) For the purposes of this subsection, a request for authorization or preauthorization for treatment of an enrollee with a diagnosis of substance use disorder shall be considered urgent by the provider and the managed care organization.

(3) The department for Medicaid Services shall designate a single nationally recognized clinical review criteria for the department and all Medicaid managed care organizations to use to determine if a given Medicaid physical health service is medically necessary and clinically appropriate, and a single nationally recognized clinical review criteria to use to determine if a given Medicaid behavioral health service is medically necessary and clinically appropriate. If the designated clinical review criteria does not cover a specific service, the department for Medicaid Services shall prescribe the medical necessity criteria to be used by the department and all Medicaid managed care organizations for that specific service.

(4) Each Medicaid managed care organization shall report on a monthly basis to the Department for Medicaid Services information prescribed by the department that details:

(a) The number and dollar value of claims received that were denied, suspended, or approved for payment;

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

(c) 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 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

(d) The data required in paragraphs (a), (b), and (c) of this subsection shall be separately reported by provider category, as prescribed by the Department for Medicaid Services, and which 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.

(5) On a monthly basis, the Department for Medicaid Services 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;

(6) Any Medicaid managed care organization that fails to comply with this section and Sections 1, 3, 4, and 5 of this Act may be subject to:

(a) Revocation of its certificate of authority or license to operate as a health maintenance organization or insurer pursuant to KRS Chapter 304;

(b) Penalties or other remedies established in KRS 304.17A-700 to 304.17A-730; and

(c) Fines, penalties, and sanctions, including termination, as established under its Medicaid managed care contract with the Commonwealth.

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

(1) A Medicaid managed care organization shall comply with Section 4 of this Act.

(2) (a) The Department for Medicaid Services shall not automatically assign a Medicaid enrollee to a Medicaid managed care organization unless there is at least one (1) acute care hospital located within the distance requirements

of Section 4 of this Act which is a participating provider with the Medicaid managed care organization.

(b) If a hospital or a primary care provider terminates participation with a Medicaid managed care organization, any enrollee of that hospital or of the primary care provider within the immediately preceding year shall be permitted to change Medicaid managed care organizations outside of the open enrollment period.

➔Section 4. KRS 304.17A-515 is amended to read as follows:

(1) A managed care plan shall arrange for a sufficient number and type of primary care providers and specialists throughout the plan's service area to meet the needs of enrollees. Each managed care plan shall demonstrate that it offers:

(a) An adequate number of accessible acute care hospital services, where ***physically*** available;

(b) An adequate number of accessible primary care providers, including family practice and general practice physicians, internists, obstetricians/gynecologists, and pediatricians, where available;

(c) An adequate number of accessible specialists and subspecialists, and when the specialist needed for a specific condition is not represented on the plan's list of participating specialists, enrollees have access to nonparticipating health care providers with prior plan approval;

(d) The availability of specialty services; and

(e) A provider network that meets the following accessibility requirements:

1. For urban areas, a provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence or work, to the extent that services are available; or

2. For areas other than urban areas, a provider network that makes

available primary care physician services, hospital services, and pharmacy services within thirty (30) minutes or thirty (30) miles of each enrollee's place of residence or work, to the extent those services are available. All other providers shall be available to all persons enrolled in the plan within fifty (50) minutes or fifty (50) miles of each enrollee's place of residence or work, to the extent those services are available.

(2) A managed care plan shall provide telephone access to the plan during business hours to ensure plan approval of nonemergency care. A managed care plan shall provide adequate information to enrollees regarding access to urgent and emergency care.

(3) A managed care plan shall establish reasonable standards for waiting times to obtain appointments, except as provided for emergency care.

➔Section 5. KRS 304.17A-576 is amended to read as follows:

(1) An insurer issuing a managed care plan shall notify an applicant of its determination regarding a properly submitted application for credentialing within ***forty-five (45)***~~[ninety (90)]~~ days of receipt of an application containing all information required by the most recent version of the Council for Affordable ***Quality*** Healthcare (CAQH) credentialing form. Nothing in this section shall prevent an insurer from requiring information beyond that contained in the credentialing form to make a determination regarding the application.

(2) The ***forty-five (45)***~~[ninety (90)]~~ day requirement set forth in subsection (1) of this section shall not apply if the failure to notify is due to or results from, in whole or in part, acts or events beyond the control of the insurer issuing a managed care plan, including but not limited to acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbances, riots, or complete or partial disruptions of facilities.

(3) Following credentialing, the applicant and, upon the applicant's signing of a contract

with the managed care plan, the insurer shall make payments to the applicant for services rendered during the credentialing process in accordance with procedures for reimbursement for participating providers.

(4) An applicant for which an application for credentialing is denied shall be reimbursed, if the enrollee is enrolled in a plan which provides for out-of-network benefits, by the insurer issuing a managed care plan in accordance with procedures for reimbursement to nonparticipating providers.

➔Section 6. KRS 304.17A-700 is amended to read as follows:

As used in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123:

(1) "Adjudicate" means an insurer pays, contests, or denies a clean claim;

(2) "Claims payment time frame" means the time period prescribed under KRS 304.17A-702 following receipt of a clean claim from a provider at the address published by the insurer, whether it is the address of the insurer or a delegated claims processor, within which an insurer is required to pay, contest, or deny a health care claim;

(3) "Clean claim" means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:

(a) A clean claim from an institutional provider shall consist of:

1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;

2. Entries stated as mandatory by the NUBC; and

3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

(b) A clean claim for dentists shall consist of the form and data set approved by

the American Dental Association.

(c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.

(d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

(4) "Commissioner" means the commissioner of the Department of Insurance;

(5) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services;

(6) "Department" means the Department of Insurance;

(7) "Electronic" or "electronically" means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;

(8) "Health benefit plan" has the same meaning as provided in KRS 304.17A-005;

(9) "Health care provider" or "provider" means a provider licensed in Kentucky as defined in KRS 304.17A-005 and, for the purposes of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, ***and Section 1 of this Act,*** 304.14-135, and 304.99-123 only, shall include physical therapists licensed under KRS Chapter 327, psychologists licensed under KRS Chapter 319, and social workers licensed under KRS Chapter 335. Nothing contained in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall be construed to include physical therapists, psychologists, and social workers as a health care provider or provider under KRS 304.17A-005;

(10) "Health claim attachments" means medical information from a covered person's medical record required by the insurer containing medical information relating to the diagnosis, the treatment, or services rendered to the covered person and as may be required pursuant to KRS 304.17A-720;

(11) "Institutional provider" means a health care facility licensed under KRS Chapter 216B;

(12) "Insurer" has the same meaning provided in KRS 304.17A-005;

(13) "Kentucky Uniform Billing Committee (KUBC)" means the committee of health care providers, governmental payors, and commercial insurers established as a local arm of NUBC to implement the bill requirements of the NUBC and to prescribe any additional billing requirements unique to Kentucky insurers;

(14) "National Uniform Billing Committee (NUBC)" means the national committee of health care providers, governmental payors, and commercial insurers that develops the national uniform billing requirements for institutional providers as referenced in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, secs. 300gg et seq.;

(15) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person; and

(16) "Utilization review" has the same meaning as provided in KRS 304.17A-600(18).