AN ACT relating to Medicaid managed care organizations.

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

➔Section 1. KRS 205.533 is amended to read as follows:

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

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

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

1. Provider relations representatives for behavioral health;

2. Provider relations representatives for physical health; and

3. Provider contract representatives for provider contract changes;

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

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

1. Internal appeals; and

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

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

➔Section 2. KRS 205.534 is amended to read as follows:

(1) A Medicaid managed care organization ***with whom the Department for Medicaid***

Services contracts for the delivery of Medicaid services shall:

(a) Provide:

1. A toll-free telephone line for providers to contact the insurer for claims resolution for forty (40) hours a week during normal business hours in this state;
2. A toll-free telephone line for providers to submit requests for authorizations of covered services during normal business hours and extended hours in this state on Monday and Friday through 6 p.m., including federal holidays;
3. With regard to any adverse payment or coverage determination, copies of all documents, records, and other information relevant to a determination, including medical necessity criteria and any processes, strategies, or evidentiary standards relied upon, if requested by the provider. Documents, records, and other information required to be provided under this paragraph shall be provided at no cost to the provider; and
4. For any adverse payment or coverage determination, a written reply in sufficient detail to inform the provider of all reasons for the determination. The written reply shall include information about the provider's right to request and receive at no cost to the provider documents, records, and other information under subparagraph 3. of this paragraph;

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

1. Any clean claim that remains unpaid in violation of KRS 304.17A-700 to 304.17A-730; and
2. Any claim that remains unpaid for forty-five (45) days or more after the

date the claim is received by the managed care organization and that individually or in the aggregate exceeds two thousand five hundred dollars ($2,500);

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

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

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

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

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

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

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

3. Ensuring that, following the resolution of an appeal that results in a determination that a monetary amount is owed to a provider, payment is made in full to the provider within thirty (30) days from the date on

which the appeal was resolved. Payments required under this subparagraph shall include:

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

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

(e) With regard to provider audits:

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

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

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

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

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

b. An explanation of the purpose of the audit;

c. The number of records being audited;

d. The timeframe covered by the records being audited;

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

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

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

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

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

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

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

initiating a provider audit;

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

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

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

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

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

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

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

8. Allow the provider to submit amended claims within thirty (30) calendar days of the discovery of a clerical or recordkeeping error in

lieu of recoupment if the services were otherwise provided in accordance with state and federal law;

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

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

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

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

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

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

i. The enrollee requests an extension; or

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

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

i. The provider or enrollee requests an extension; or

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

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

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

(b) A decision by a managed care organization on an authorization or preauthorization request for physical, behavioral, or other medically necessary services shall be made in a timely and consistent manner so that Medicaid members with comparable medical needs receive a comparable, consistent level, amount, and duration of services as supported by the member's medical condition, records, and previous affirmative coverage decisions.

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

1. The number and dollar value of claims received that were denied, suspended, or approved for payment;

2. The number of requests for authorization of services and the number of such requests that were approved and denied;

3. The number of internal appeals and grievances filed by members and by providers and the type of service related to the grievance or appeal, ***the total dollar amount of all denials being appealed,*** the time of resolution, the number of internal appeals and grievances where the initial denial was overturned and the type of service and dollar amount associated with the overturned denials;~~[and]~~

4. ***For each internal appeal or grievance not resolved within sixty (60) calendar days, the name of the provider who filed the unresolved internal appeal or grievance, the dollar amount of the claim that was denied if a denial is being appealed, the reason for the delay in resolving the internal appeal or grievance, the current status of the internal appeal or grievance, and the outcome determination if rendered prior to the filing of the report; and***

5. Any other information required by the department.

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

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

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

(a) The number and dollar value of all claims that were received by the managed care organization and the number of dollar value of those claims

that were approved for payment, denied, or suspended;

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

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

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

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

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