

1 AN ACT relating to service improvements in the Medicaid program.

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

3 ➔SECTION 1. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
4 READ AS FOLLOWS:

5 *(1) The Department for Medicaid Services shall limit the total number of awarded*
6 *Medicaid managed care contracts to administer the Medicaid program to no*
7 *more than three (3) managed care organizations, except as provided in*
8 *subsections (4) and (5) of this section.*

9 *(2) Notwithstanding any state law to the contrary, the Department for Medicaid*
10 *Services shall establish a rating scale to evaluate current or new entities that have*
11 *bid to operate as a Medicaid managed care organization. The Department for*
12 *Medicaid Services shall award the Medicaid managed care contracts to the three*
13 *(3) managed care organizations scoring highest on the rating scale.*

14 *(3) Notwithstanding any state law to the contrary, the rating scale shall contain the*
15 *following assessment criteria for managed care organizations that have*
16 *previously provided Medicaid managed care within the Commonwealth:*

17 *(a) 1. Information relating to the actual medical loss ratio of each managed*
18 *care organization as it performs contracts to provide Medicaid services*
19 *shall be provided by the Department for Medicaid Services, and five*
20 *percent (5%) of the overall rating shall be based on that medical loss*
21 *ratio data.*

22 *2. The managed care organization with the highest medical loss ratio as*
23 *measured pursuant to this paragraph shall receive a score of one*
24 *hundred percent (100%) of the available score pursuant to this*
25 *paragraph.*

26 *3. The managed care organization with the second-highest medical loss*
27 *ratio as measured pursuant to this paragraph shall receive a score of*

1 not less than ninety-five percent (95%) of the available score pursuant
2 to this paragraph.

3 4. The managed care organization with the third-highest medical loss
4 ratio as measured pursuant to this paragraph shall receive a score of
5 not less than ninety percent (90%) of the available score pursuant to
6 this paragraph.

7 5. The remaining managed care organizations with lower medical loss
8 ratios than the three (3) managed care organizations designated
9 pursuant to subparagraphs 2., 3., and 4. of this paragraph shall
10 receive scores of not more than eighty-five percent (85%) of the score
11 available pursuant to this paragraph;

12 **(b) 1. Twenty percent (20%) of the rating shall be based on the quality and**
13 **access measures scores developed and provided by the Department for**
14 **Medicaid Services that are used by members to select a managed care**
15 **organization.**

16 2. The highest-rated managed care organization pursuant to this
17 paragraph shall receive a score of one hundred percent (100%) of the
18 available score pursuant to this paragraph.

19 3. The second-highest-scoring managed care organization pursuant to
20 this paragraph shall receive a score of not less than ninety-five percent
21 (95%) of the available score pursuant to this paragraph.

22 4. The third-highest-scoring managed care organization pursuant to this
23 paragraph shall receive a score of not less than ninety percent (90%)
24 of the available score pursuant to this paragraph.

25 5. The remaining managed care organizations shall receive scores of not
26 more than eighty-five percent (85%) of the available score pursuant to
27 this paragraph;

1 (c) 1. Twelve and one-half percent (12.5%) of the rating scale shall be based
2 on the numbers and severity of corrective actions taken against a
3 managed care organization when the Department for Medicaid
4 Services has found that the managed care organization was violating
5 its contract with the state to provide Medicaid services. The corrective
6 actions considered shall include letters of concern issued, corrective
7 action plans required, sanctions issued, and cease-and-desist orders
8 issued.

9 2. The managed care organization with the least number and severity of
10 corrective actions issued shall receive a score of one hundred percent
11 (100%) of the available score pursuant to this paragraph.

12 3. The managed care organization with the second-lowest number and
13 severity of corrective actions issued shall receive a score of not less
14 than ninety-five percent (95%) of the available score pursuant to this
15 paragraph.

16 4. The managed care organization with the third-lowest number and
17 severity of corrective actions issued shall receive a score of not less
18 than ninety percent (90%) of the available score pursuant to this
19 paragraph.

20 5. The remaining managed care organizations with higher corrective
21 actions issued and higher severity of corrective actions shall receive
22 scores of not more than eighty-five percent (85%) of the available
23 score pursuant to this paragraph;

24 (d) 1. Twelve and one-half percent (12.5%) of the rating scale shall be based
25 on the aggregate percentage of prompt payment of clean claims within
26 thirty (30) days by each managed care organization over the sum of
27 time that the managed care organization has operated in the

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2. The managed care organization with the highest percentage of clean claims paid promptly within thirty (30) days over the sum of the time that the managed care organization has provided Medicaid managed care within the Commonwealth shall receive a score of one hundred percent (100%) of the available score pursuant to this paragraph.

3. The managed care organization with the second-highest percentage of clean claims paid promptly within thirty (30) days over the sum of the time that the managed care organization has provided Medicaid managed care within the Commonwealth shall receive a score of not less than ninety-five percent (95%) of the available score pursuant to this paragraph.

4. The managed care organization with the third-highest percentage of clean claims paid promptly within thirty (30) days over the sum of the time that the managed care organization has provided Medicaid managed care within the Commonwealth shall receive a score of not less than ninety percent (90%) of the available score pursuant to this paragraph.

5. The remaining managed care organizations with lower percentages of clean claims paid promptly within thirty (30) days over the sum of the time that the managed care organizations have provided Medicaid managed care within the Commonwealth shall receive no more than eighty-five percent (85%) of the available score pursuant to this paragraph; and

(e) The remaining fifty percent (50%) of the rating scale shall follow the existing request for proposal procurement process that complies with KRS Chapter 45A in the following manner:

- 1 1. The lowest bid shall be assigned a score of one hundred percent
2 (100%) of the available score within this paragraph;
- 3 2. Bids that are within one hundred and twenty-five percent (125%) of
4 the lowest bid received shall be scored under this paragraph at a two
5 percent (2%) reduction in score for every ten percent (10%) exceeding
6 the lowest received bid;
- 7 3. Bids that are greater than one hundred twenty-five percent (125%) but
8 less than one hundred fifty percent (150%) of the lowest bid received
9 shall be scored under this paragraph at a five percent (5%) reduction
10 in score for every ten percent (10%) exceeding the lowest received bid;
11 and
- 12 4. Bids that are greater than one hundred fifty percent (150%) of the
13 lowest bid received shall be scored under this paragraph at a ten
14 percent (10%) reduction in score for every ten percent (10%)
15 exceeding the lowest received bid.
- 16 (4) A managed care organization that is commencing operation as a managed care
17 organization in the Commonwealth and which has no history as a managed care
18 organization in the Commonwealth or in the United States and is not
19 substantially similar to a previous managed care organization operating in the
20 Commonwealth may be considered under the rating scale established in
21 subsection (3) of this section as follows:
- 22 (a) The managed care organization shall have submitted the lowest bid received
23 pursuant to the request-for-proposal procurement process that complies
24 with KRS Chapter 45A; and
- 25 (b) If the managed care organization that is commencing initial operation in
26 the Commonwealth is selected, then the Department for Medicaid Services
27 shall conduct full audits at least once every two (2) months for the duration

1 of the new managed care organization's contract to assess and calculate the
2 managed care organization's performance in the metrics measured in
3 paragraphs (a), (b), (c), and (d) of subsection (3) of this section. If the
4 managed care organization's performance under the metrics when
5 combined with its score under paragraph (e) of subsection (3) of this section
6 in any four (4) month period does not result in the highest, the second-
7 highest, or the third-highest score when recalculated, then the managed
8 care organization's contract shall be immediately terminated and the
9 existing Medicaid managed care organizations shall be assigned all
10 members of the terminated managed care organization.

11 (5) A managed care organization that has not previously provided managed care
12 services to Medicaid members in the Commonwealth but that has provided
13 managed care services to Medicaid members in other states may be considered
14 under the rating scale established in subsection (3) of this section as follows:

15 (a) The managed care organization shall have submitted a bid that is at least
16 within ten percent (10%) of the lowest bid received pursuant to the request-
17 for-proposal procurement process that complies with KRS Chapter 45A;

18 (b) The managed care organization shall submit or reference data measures
19 that are the same or similar to the data requested in paragraphs (a), (b), (c),
20 and (d) of subsection (3) of this section;

21 (c) The Department for Medicaid Services shall analyze the bid by the managed
22 care organization that is entering the Commonwealth's market for the first
23 time and determine if the data submitted by the managed care organization
24 in paragraphs (a) and (b) of this subsection constitutes a bid that would be
25 in the top highest-scoring bids pursuant to the rating scale established in
26 subsection (3) of this section; and

27 (d) If the managed care organization that is entering the Commonwealth's

1 market for the first time is selected, then the Department for Medicaid
2 Services shall conduct full audits at least once every two (2) months for the
3 duration of the new managed care organization's contract to assess and
4 calculate the managed care organization's performance in the metrics
5 measured in paragraphs (a), (b), (c), and (d) of subsection (3) of this
6 section. If the managed care organization's performance under the metrics,
7 when combined with its score under paragraph (e) of subsection (3) of this
8 section in any four (4) month period, does not result in the highest, the
9 second-highest, or the third-highest score when recalculated, then the
10 managed care organization's contract shall be immediately terminated, and
11 the existing Medicaid managed care organizations shall be assigned all
12 members of the terminated managed care organization.

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

15 (1) The Department for Medicaid Services shall require that each Medicaid service
16 provided by a rural provider within a rural county be reimbursed at least at the
17 median amount paid to an urban health care provider for the same service within
18 the nearest metropolitan statistical area to the rural county where the service was
19 performed.

20 (2) (a) If the Department for Medicaid Services discovers or is made aware of an
21 underpayment that occurred pursuant to subsection (1) of this section, then
22 the Department for Medicaid Services shall require the Medicaid managed
23 care organization that committed the underpayment to correct that
24 underpayment within thirty (30) days.

25 (b) If an underpayment is not corrected within thirty (30) days, then the
26 managed care organization shall pay three (3) times the interest rate
27 established in KRS 304.17A-730 to the provider that was underpaid

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pursuant to this section.