AN ACT relating to service improvements in the Medicaid program.

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

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

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

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

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

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

2. The managed care organization with the highest medical loss ratio as measured pursuant to this paragraph 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 medical loss ratio as measured pursuant to this paragraph 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 medical loss ratio as measured pursuant to this paragraph 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 medical loss ratios than the three (3) managed care organizations designated pursuant to subparagraphs 2., 3., and 4. of this paragraph shall receive scores of not more than eighty-five percent (85%) of the score available pursuant to this paragraph;

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

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

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

4. The third-highest-scoring managed care organization pursuant to this paragraph 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 shall receive scores of not more than eighty-five percent (85%) of the available score pursuant to this paragraph;

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

2. The managed care organization with the least number and severity of corrective actions issued 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-lowest number and severity of corrective actions issued 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-lowest number and severity of corrective actions issued 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 higher corrective actions issued and higher severity of corrective actions shall receive scores of not more than eighty-five percent (85%) of the available score pursuant to this paragraph;

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

Commonwealth.

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. The lowest bid shall be assigned a score of one hundred percent (100%) of the available score within this paragraph;

2. Bids that are within one hundred and twenty-five percent (125%) of the lowest bid received shall be scored under this paragraph at a two percent (2%) reduction in score for every ten percent (10%) exceeding the lowest received bid;

3. Bids that are greater than one hundred twenty-five percent (125%) but less than one hundred fifty percent (150%) of the lowest bid received shall be scored under this paragraph at a five percent (5%) reduction in score for every ten percent (10%) exceeding the lowest received bid; and

4. Bids that are greater than one hundred fifty percent (150%) of the lowest bid received shall be scored under this paragraph at a ten percent (10%) reduction in score for every ten percent (10%) exceeding the lowest received bid.

(4) A managed care organization that is commencing operation as a managed care organization in the Commonwealth and which has no history as a managed care organization in the Commonwealth or in the United States and is not substantially similar to a previous managed care organization operating in the Commonwealth may be considered under the rating scale established in subsection (3) of this section as follows:

(a) The managed care organization shall have submitted the lowest bid received pursuant to the request-for-proposal procurement process that complies with KRS Chapter 45A; and

(b) If the managed care organization that is commencing initial operation in the Commonwealth is selected, then the Department for Medicaid Services shall conduct full audits at least once every two (2) months for the duration

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

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

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

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

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

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

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

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

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

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

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

pursuant to this section.