

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 Commonwealth shall limit the total number of awarded Medicaid managed*  
6 *care contracts to administer the Medicaid program to no more than two (2)*  
7 *managed care organizations, except as provided in subsections (4) and (5) of this*  
8 *section.*

9 *(2) Notwithstanding any state law to the contrary, in evaluating which two (2)*  
10 *managed care organizations to select for future contracts with the*  
11 *Commonwealth, the selecting state government agency shall establish a rating*  
12 *scale to evaluate current or new entities that have bid to operate as a Medicaid*  
13 *managed care organization within the Commonwealth. This rating scale shall be*  
14 *the method used by the selecting state government agency to select the two (2)*  
15 *managed care organizations to operate the Medicaid program. The two (2)*  
16 *highest-scoring managed care organizations under the criteria established in the*  
17 *rating scale shall be awarded the contracts to operate the Medicaid program.*

18 *(3) The rating scale and the selecting state government agency shall utilize the*  
19 *following information to assess the applying managed care organizations when*  
20 *an applying managed care organization has previously provided Medicaid*  
21 *managed care to Medicaid members within the Commonwealth:*

22 *(a) 1. Five percent (5%) of the rating shall be based on the medical loss ratio*  
23 *data provided by the Department for Medicaid Services. Information*  
24 *relating to the actual medical loss ratio of each managed care*  
25 *organization as it performs contracts to provide Medicaid services*  
26 *shall be provided by the Department for Medicaid Services.*

27 *2. The managed care organization with the highest medical loss ratio as*

1 measured pursuant to this paragraph shall receive a score of one  
2 hundred percent (100%) of the score available pursuant to this  
3 paragraph.

4 3. The managed care organization with the second highest medical loss  
5 ratio as measured pursuant to this paragraph shall receive a score of  
6 not less than ninety-five percent (95%) of the score available pursuant  
7 to this paragraph.

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

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

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

20 3. The second-highest-scoring managed care organization pursuant to  
21 this paragraph shall receive a score of not less than ninety-five percent  
22 (95%) of the score available pursuant to this paragraph.

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

26 (c) 1. Twelve and one-half percent (12.5%) of the rating scale shall be based  
27 on the numbers and severity of corrective actions taken against a

1 managed care organization when the Department for Medicaid  
2 Services has found that the managed care organization was violating  
3 its contract with the state to provide Medicaid services. The corrective  
4 actions considered shall include letters of concern issued, corrective  
5 action plans required, sanctions issued, and cease-and-desist orders  
6 issued.

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

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

14 4. The remaining managed care organizations with the higher corrective  
15 actions issued and higher severity of corrective actions shall receive  
16 scores of not more than eighty-five percent (85%) of the score  
17 available pursuant to this paragraph;

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

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

- 1           3. The managed care organization with the second-highest percentage of  
2           clean claims paid promptly within thirty (30) days over the entirety of  
3           the time that the managed care organization has provided Medicaid  
4           managed care within the Commonwealth shall receive a score of not  
5           less than ninety-five percent (95%) of the score available pursuant to  
6           this paragraph.
- 7           4. The remaining managed care organizations with lower percentages of  
8           clean claims paid promptly within thirty (30) days over the entirety of  
9           the time that the managed care organizations have provided Medicaid  
10           managed care within the Commonwealth shall receive no more than  
11           eighty-five percent (85%) of the score available pursuant to this  
12           paragraph; and
- 13       (e) The remaining fifty percent (50%) of the rating scale shall follow the  
14       existing request for proposal procurement process that complies with KRS  
15       Chapter 45A in the following manner:
- 16           1. The lowest bid shall be assigned a score of one hundred percent  
17           (100%) of the score available within this paragraph;
- 18           2. Bids that are within one hundred and twenty-five percent (125%) of  
19           the lowest bid received shall be scored under this paragraph at a two  
20           percent (2%) reduction in score for every ten percent (10%) exceeding  
21           the lowest received bid;
- 22           3. Bids that are between one hundred twenty-five percent (125%) and  
23           one hundred fifty percent (150%) of the lowest bid received shall be  
24           scored under this paragraph at a five percent (5%) reduction in score  
25           for every ten percent (10%) exceeding the lowest received bid; and
- 26           4. Bids that are greater than one hundred fifty percent (150%) of the  
27           lowest bid received shall be scored under this paragraph at a ten

1                   percent (10%) reduction in score for every ten percent (10%)  
2                   exceeding the lowest received bid.

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

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

12 (b) If the managed care organization that is commencing initial operation in  
13 the Commonwealth is selected then the Department for Medicaid Services  
14 shall conduct full audits at least once every two (2) months for the duration  
15 of the new managed care organization's contract to assess and calculate the  
16 managed care organization's performance in the metrics measured in  
17 paragraphs (a), (b), (c), and (d) of subsection (3) of this section. If the  
18 managed care organization's performance under the metrics when  
19 combined with its score under paragraph (e) of subsection (3) of this section  
20 in any four (4) month period does not result in the highest or second-  
21 highest score when recalculated, then the managed care organization's  
22 contract shall be immediately terminated and the existing Medicaid  
23 managed care organizations shall be assigned all members of the  
24 terminated managed care organization; and

25 (c) Because of the risk of contract termination under this subsection, if the  
26 Department for Medicaid Services awards a contract under this subsection,  
27 then it may issue three (3) contracts to provide Medicaid managed care

1           services for the duration of that contract. The third managed care  
2           organization offered a contract shall be the organization that received the  
3           third-highest rating under the rating scale established in subsection (3) of  
4           this section.

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

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

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

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

21          (d) If the managed care organization that is entering the Kentucky market for  
22          the first time is selected, then the Department for Medicaid Services shall  
23          conduct full audits at least once every two (2) months for the duration of the  
24          new managed care organization's contract to assess and calculate the  
25          managed care organization's performance in the metrics measured in  
26          paragraphs (a), (b), (c), and (d) of subsection (3) of this section. If the  
27          managed care organization's performance under the metrics, when

1 combined with its score under paragraph (e) of subsection (3) of this section  
 2 in any four (4) month period, does not result in the highest-or second-  
 3 highest score when recalculated then the managed care organization's  
 4 contract shall be immediately terminated, and the existing Medicaid  
 5 managed care organizations shall be assigned all members of the  
 6 terminated managed care organization; and

7 (e) Because of the risk of contract termination under this subsection, if the  
 8 Department for Medicaid Services awards a contract to a managed care  
 9 organization under this subsection, then it may issue three (3) contracts to  
 10 provide Medicaid managed care services for the duration of that contract.  
 11 The third managed care organization offered a contract shall be the  
 12 organization that received the third-highest rating under the rating scale  
 13 established in subsection (3) of this section.

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

16 (1) Any Medicaid managed care organization contracted to provide Medicaid  
 17 services shall, on a quarterly basis, provide all payment schedules utilized to  
 18 reimburse for Medicaid services within the Commonwealth over the previous  
 19 three (3) months to the Medicaid Oversight and Advisory Committee.

20 (2) The Cabinet for Health and Family Services shall require that each Medicaid  
 21 service provided by a rural provider within a rural county be reimbursed at least  
 22 at the median amount paid to an urban health care provider for the same service  
 23 within the nearest metropolitan statistical area to the rural county where the  
 24 service was performed.

25 (3) (a) If the Cabinet for Health and Family Services discovers or is made aware of  
 26 an underpayment that occurred pursuant to subsection (2) of this section,  
 27 including via analysis of data provided pursuant to subsection (1) of this

1           section, then the Cabinet for Health and Family Services shall require the  
2           Medicaid managed care organization that committed the underpayment to  
3           correct that underpayment within thirty (30) days.  
4           (b) If an underpayment is not corrected within thirty (30) days, then the  
5           managed care organization shall pay three (3) times the interest rate  
6           established in KRS 304.17A-730 to the provider that was underpaid  
7           pursuant to this section.