

1 AN ACT relating to 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) As used in this section, unless the context requires otherwise:

6 (a) "Managed care organization" has the same meaning as in KRS 205.532;

7 (b) "Material change" means a change to a contract, the occurrence and
8 timing of which is not otherwise clearly identified in the contract, that
9 decreases the health care provider's payment or compensation or changes
10 the administrative procedures in a way that may reasonably be expected to
11 significantly increase the provider's administrative expense, and includes
12 any changes to provider network requirements or inclusion in any new or
13 modified insurance products; and

14 (c) "Participating provider" means a Medicaid credentialed and enrolled
15 provider of health services.

16 (2) Each managed care organization shall establish procedures for changing an
17 existing agreement with a participating provider that shall comply with the
18 requirements of this section.

19 (3) (a) If a managed care organization makes any material change to an
20 agreement it has entered into with a participating provider for the provision
21 of Medicaid-covered services, the managed care organization shall provide
22 the participating provider with at least ninety (90) day notice of the material
23 change.

24 (b) The notice of a material change required shall:

25 1. Provide the proposed effective date of the change;

26 2. Include a description of the material change;

27 3. Include a statement that the participating provider has the option to

1 either accept or reject the proposed material change in accordance
2 with this section;

3 4. Provide the name, business address, telephone number, and email
4 address of a representative of the managed care organization to
5 discuss the material change, if requested by the participating provider;

6 5. a. Provide notice of the opportunity for a meeting using real-time
7 communication to discuss the proposed changes if requested by
8 the participating provider. If requested by the provider, the
9 opportunity to communicate to discuss the proposed changes
10 may occur via email instead of real-time communication.

11 b. For purposes of this subparagraph, "real-time communication"
12 means any mode of telecommunications in which all users can
13 exchange information instantly or with negligible latency and
14 includes the use of traditional telephone, mobile telephone,
15 teleconferencing, and videoconferencing; and

16 6. Provide notice that upon three (3) material changes in a twelve (12)
17 month period, the provider may request a copy of the contract with
18 material changes consolidated into it. Provision of the copy of the
19 contract by the managed care organization shall be for informational
20 purposes only and shall have no effect on the terms and conditions of
21 the contract.

22 (c) A managed care organization shall utilize a method of delivery of the
23 material change notice that provides confirmation receipt by the
24 participating provider evidenced by a written or electronic signature.

25 (d) The notice of proposed material change shall be sent in an orange-colored
26 envelope with the phrase "ATTENTION! CONTRACT AMENDMENT
27 ENCLOSED!" in no less than fourteen (14) point boldface Times New

1 Roman font printed on the front of the envelope. This color of envelope
2 shall be used for the sole purpose of communicating proposed material
3 changes and shall not be used for other types of communication from an
4 insurer.

5 (4) If a material change relates to the participating provider's inclusion in any new
6 or modified insurance products, or proposes changes to the participating
7 provider's membership networks:

8 (a) The material change shall only take effect upon the acceptance of the
9 participating provider, evidenced by a written signature; and

10 (b) The notice of the proposed material change shall be sent by certified mail,
11 return receipt requested to the participating provider's point of contact, as
12 set forth in the agreement, and to the provider's principal place of business
13 as it appears on the Secretary of State's website, if the provider is an entity
14 required to register with the Secretary of State's office as a business entity.

15 (5) For any other material change not addressed in subsection (4) of this section:

16 (a) The material change shall take effect on the date provided in the notice
17 unless the participating provider objects to the change in accordance with
18 this subsection;

19 (b) A participating provider who objects under this subsection shall do so in
20 writing and the written protest shall be delivered to the managed care
21 organization within thirty (30) days of the participating provider's receipt of
22 notice of the proposed material change;

23 (c) Within thirty (30) days following the managed care organization's receipt of
24 the written objection, the managed care organization and the participating
25 provider shall confer in an effort to reach an agreement on the proposed
26 change or any counter-proposals offered by the participating provider;

27 (d) If the managed care organization and participating provider fail to reach an

1 agreement during the thirty (30) day negotiation period described in
2 paragraph (c) of this subsection, then the parties shall unwind their
3 relationship, provide notice to patients and other affected parties, and
4 terminate the contract pursuant to its original terms within thirty (30) days;
5 and

6 (e) The managed care organization shall be limited to no more than one (1)
7 material change during the term of the contract and may not reduce the
8 provider's payment or compensation by more than ten percent (10%) of the
9 provider's prior payment or compensation.

10 (6) If a managed care organization makes a change to an agreement that changes an
11 existing prior authorization, precertification, notification, or referral program, or
12 changes an edit program or specific edits, the managed care organization shall
13 provide notice of the change to the participating provider at least fifteen (15) days
14 prior to the change.

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

17 Any contract entered into or renewed by the Cabinet for Health and Family Services,
18 or any department, division, or unit thereof, on or after the effective date of this Act for
19 the delivery of Medicaid services by a managed care organization shall:

20 (1) Be in compliance with 42 U.S.C. sec. 1396u-2 and 42 C.F.R. pt. 438 Subpart K,
21 including but not limited to federal provisions related to amending contracts
22 between the Department for Medicaid Services and managed care organizations;

23 (2) Require managed care organizations to ensure that financial requirements and
24 treatment limitations applicable to benefits covering the treatment of a mental
25 health condition are no more restrictive than those applicable to the treatment of
26 a physical health condition;

27 (3) Include processes and procedures that shall be utilized by the Department for

- 1 Medicaid Services to ensure and monitor compliance with requirements
2 established in 42 C.F.R. pt. 438 Subpart K and subsection (2) of this section;
3 (4) Require each managed care organization to submit to the Department for
4 Medicaid Services any analyses, reports, data, or other information that the
5 department determines may be necessary for the processes and procedures
6 described in subsection (3) of this section; and
7 (5) Require each managed care organization to submit an annual report to the
8 department on or before April 1 of each year that contains the following:
9 (a) A comparative analysis of nonquantitative limitations that complies with 42
10 U.S.C. sec. 300qq-26(a)(8); and
11 (b) A comparison of payments made to all physical health providers, by
12 provider type, and all mental health providers, by provider type as indexed to
13 the national Medicare physicians fee schedule for the calendar year covered
14 by the report.

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

- 17 (1) Beginning July 1, 2027, in order to be eligible for reimbursement by the
18 Department for Medicaid Services or a managed care organization with whom
19 the department has contracted for the delivery of Medicaid services:
20 (a) A program operated by an agency licensed under KRS 222.231 shall be fully
21 accredited by the Joint Commission, Commission on Accreditation of
22 Rehabilitation Facilities, Council on Accreditation, or another nationally
23 recognized accrediting organization with comparable standards approved by
24 the Department for Medicaid Services pursuant to subsection (3) of this
25 section; and
26 (b) A narcotic treatment program shall be licensed by the cabinet.
27 (2) Narcotic treatment programs licensed by the cabinet may utilize buprenorphine

products approved by the United States Food and Drug Administration for the treatment of substance use disorders.

(3) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A necessary to carry out the provisions of this section, including but not limited to administrative regulations related to the licensing of narcotic treatment programs and the certification of programs operated by agencies licensed under KRS 222.231.

➔Section 4. KRS 205.522 is amended to read as follows:

(1) With respect to the administration and provision of Medicaid benefits pursuant to this chapter, the Department for Medicaid Services, any managed care organization contracted to provide Medicaid benefits pursuant to this chapter, and the state's medical assistance program shall be subject to, and comply with, **all provisions of this chapter related to the state's medical assistance program and** the following, as applicable:

(a) KRS 304.17A-129;

(b) KRS 304.17A-145;

(c) KRS 304.17A-163;

(d) KRS 304.17A-1631;

(e) KRS 304.17A-167;

(f) ~~[KRS 304.17A-235;~~

~~(g)]KRS 304.17A-257;~~

(g)~~[(h)]~~ KRS 304.17A-259;

(h)~~[(i)]~~ KRS 304.17A-263;

(i)~~[(j)]~~ KRS 304.17A-264;

(j)~~[(k)]~~ KRS 304.17A-515;

(k)~~[(l)]~~ KRS 304.17A-580;

(l)~~[(m)]~~ KRS 304.17A-600, 304.17A-603, and 304.17A-607;~~[and]~~

1 (m) KRS 304.17A-661;

2 (n) KRS 304.17A-700 to 304.17A-730; and

3 (o)(n) KRS 304.17A-740 to 304.17A-743.

4 (2) A managed care organization contracted to provide Medicaid benefits pursuant to
5 this chapter shall:

6 (a) Comply with the reporting requirements of KRS 304.17A-732; and

7 (b) In addition to complying with KRS 304.17A-706 as required by subsection
8 (1) of this section, provide a detailed description of the reasons for denial of
9 claims contested under KRS 304.17A-706(1). The description of reasons for
10 denial shall include:

11 1. Any information that was required to be received, but was not
12 received, in the health claim attachment;

13 2. The reason each claim was determined not to be medically necessary;
14 and

15 3. The specific law, regulation, policy, guidance, literature, publication,
16 standard of practice, or other authority the managed care organization
17 relied upon to determine that a claim was not medically necessary.

18 ➔Section 5. KRS 304.38-130 is amended to read as follows:

19 (1) The commissioner may suspend or revoke any certificate of authority issued to a
20 health maintenance organization under this subtitle if the commissioner finds that
21 any of the conditions exist for which the commissioner could suspend or revoke a
22 certificate of authority as provided in Subtitles 2 and 3 of this chapter or if the
23 commissioner finds that any of the following conditions exist:

24 (a) The health maintenance organization is operating significantly in
25 contravention of its basic organizational document or in a manner contrary to
26 that described in and reasonably inferred from any other information
27 submitted under KRS 304.38-040, unless amendments to such submissions

- 1 have been filed with and approved by the commissioner;
- 2 (b) The health maintenance organization issues evidence of coverage or uses a
3 schedule of charges for health care services which do not comply with the
4 requirements of KRS 304.38-050 or Subtitle 17A of this chapter;
- 5 (c) The health maintenance organization does not provide or arrange for health
6 care services as approved by the commissioner in KRS 304.38-050(1)(a);
- 7 (d) The certificate of need and licensure board certifies to the commissioner that
8 the health maintenance organization fails to meet the requirements of the
9 board or that the health maintenance organization is unable to fulfill its
10 obligations to furnish health care services;
- 11 (e) The health maintenance organization is no longer financially responsible and
12 may reasonably be expected to be unable to meet its obligations to enrollees
13 or prospective enrollees;
- 14 (f) The health maintenance organization, or any person on its behalf, has
15 advertised or merchandised its services in an untrue, misrepresentative,
16 misleading, deceptive, or unfair manner;
- 17 (g) The continued operation of the health maintenance organization would be
18 hazardous to its enrollees;
- 19 (h) The health maintenance organization has otherwise failed to substantially
20 comply with this subtitle; or
- 21 (i) The health maintenance organization has contracted with the Department for
22 Medicaid Services to act as a managed care organization providing Medicaid
23 benefits pursuant to KRS Chapter 205 and has exhibited willful or frequent
24 and repeated failure to comply with: ~~KRS 304.17A-700 to 304.17A-730,~~
25 ~~205.593, and 304.14-135 and KRS 205.522, 205.532 to 205.536, and~~
26 ~~304.17A-515}~~

27 **a. Section 4 of this Act;**

- 1 **b. KRS 205.532 to 205.536;**
2 **c. KRS 205.593;**
3 **d. Section 1 of this Act;**
4 **e. KRS 304.14-135;**
5 **f. KRS 304.17A-515;**
6 **g. KRS 304.17A-700 to 304.17A-730;**
7 **h. 42 U.S.C. sec. 1396u-2; or**
8 **i. 42 C.F.R. pt. 438 Subpart K.**

- 9 (2) If the certificate of authority of a health maintenance organization is suspended, the
10 health maintenance organization shall not, during the period of the suspension,
11 enroll any additional enrollees except newborn children or other newly acquired
12 dependents of existing enrollees, and shall not engage in any advertising or
13 solicitation whatsoever.
- 14 (3) If the certificate of authority of a health maintenance organization is revoked, the
15 organization shall proceed, immediately following the effective date of the order of
16 revocation, to wind up its affairs, and shall conduct no further business except as
17 may be essential to the orderly conclusion of the affairs of the organization. It shall
18 engage in no further advertising or solicitation whatsoever. The commissioner may,
19 by written order, permit the further operation of the organization as the
20 commissioner may find to be in the best interest of enrollees, to the end that
21 enrollees will be afforded the greatest practical opportunity to obtain continuing
22 health care coverage. If the commissioner permits such further operation the health
23 maintenance organization will continue to collect the periodic prepayments required
24 of enrollees.