AN ACT relating to unfair trade practices in the negotiation and offer of contracts for the provision of health care services and declaring an emergency.

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

➔SECTION 1. A NEW SECTION OF SUBTITLE 12 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Insurer" has the same meaning as in KRS 304.17A-005;

(b) "Provider" has the same meaning as in Section 3 of this Act; and

(c) "Provider agreement" means a contract, including a risk sharing arrangement as defined in KRS 304.17A-500, between an insurer and a provider for the provision of health care services.

(2) An insurer shall:

(a) Negotiate provider agreements in good faith; and

(b) Not offer provider agreements that are contracts of adhesion.

(3) A provider that enters into a provider agreement negotiated or offered by an insurer in violation of subsection (2) of this section:

(a) May elect to void any provision of the provider agreement, except provisions that are required by state or federal law; and

(b) Shall have a cause of action against the insurer to recover compensatory damages, including attorney fees, resulting from the violation.

➔Section 2. KRS 205.532 is amended to read as follows:

(1) As used in KRS 205.532 to 205.536:

(a) "Clean application" means:

1. For credentialing purposes, a credentialing application submitted by a provider to a credentialing verification organization that:

a. Is complete and correct;

b. Does not lack any required substantiating documentation; and

c. Is consistent with the requirements for the National Committee for Quality Assurance requirements; or

2. For enrollment purposes, an enrollment application submitted by a provider to the department that:

a. Is complete and correct;

b. Does not lack any required substantiating documentation;

c. Complies with all provider screening requirements pursuant to 42 C.F.R. pt. 455; and

d. Is on behalf of a provider who does not have accounts receivable with the department;

(b) "Credentialing application date" means the date that a credentialing verification organization receives a clean application from a provider;

(c) "Credentialing verification organization" means an organization that gathers data and verifies the credentials of providers in a manner consistent with federal and state laws and the requirements of the National Committee for Quality Assurance. "Credentialing verification organization" is limited to the following:

1. An organization designated by the department pursuant to subsection (3)(a) of this section; and

2. Any bona fide, nonprofit, statewide, health care provider trade association, organized under the laws of Kentucky, that has an existing contract with the department or a managed care organization, as of July 1, 2018, to perform credentialing verification activities;

(d) "Department" means the Department for Medicaid Services;

(e) "Medicaid managed care organization" or "managed care organization" means an entity for which the department has contracted to serve as a managed care organization as defined in 42 C.F.R. sec. 438.2;

(f) "Provider" has the same meaning as in KRS 304.17A-700; and

(g) "Request for proposals" has the same meaning as in KRS 45A.070.

(2) On and after January 1, 2019, every contract entered into or renewed for the delivery of Medicaid services by a managed care organization shall be in compliance with KRS 205.522, 205.532 to 205.536, and 304.17A-515.

(3) (a) Through a request for proposals, the department shall designate a single organization as a credentialing verification organization to verify the credentials of providers on behalf of all managed care organizations.

(b) Following the department's designation pursuant to this subsection, the contract between the department and the designated credentialing verification organization shall be submitted to the Government Contract Review Committee of the Legislative Research Commission for comment and review.

(c) A credentialing verification organization, designated by the department, shall be reimbursed on a per provider credentialing basis by the department. The reimbursements shall be offset or deducted equally from each Medicaid managed care organizations capitation payments.

(d) The department shall enroll and screen providers in accordance with 42 C.F.R. pt. 455 and applicable state and federal law.

(e) Each provider seeking to be enrolled and screened with the department shall make application via electronic means as determined by the department.

(f) Pursuant to federal law, all providers seeking to participate in the Medicaid program with a managed care organization shall be enrolled as a provider with the department.

(g) Each provider seeking to be credentialed with a Medicaid managed care organization shall submit a single credentialing application to the designated credentialing verification organization, or to an organization meeting the requirements of subsection (1)(c)2. of this section, if applicable. The

credentialing verification organization shall:

1. Gather all necessary documentation from each provider;

2. Within five (5) days of receipt of a credentialing application, notify the provider in writing if the application is complete;

3. Review an application for any misstatement of fact or lack of substantiating documentation;

4. Credential and provide verified credentialing information electronically to the department and to each managed care organization as requested by the provider within thirty (30) calendar days of receipt of a clean application; and

5. Conduct reevaluations of provider documentation when required pursuant to state or federal law or for the provider to maintain participation status with a managed care organization.

(4) (a) The department shall enroll a provider within sixty (60) calendar days of receipt of a clean provider enrollment application. The date of enrollment shall be the date that the provider's clean application was initially received by the department. The time limits established in this section shall be tolled or paused by a delay caused by an external entity. Tolling events include but are not limited to the screening requirements contained in 42 C.F.R. pt. 455 and searches of federal databases maintained by entities such as the United States Centers for Medicare and Medicaid Services.

(b) A Medicaid managed care organization shall:

1. Determine whether it will contract with the provider within thirty (30) calendar days of receipt of the verified credentialing information from the credentialing verification organization;~~[and]~~

2. ***Comply with and be subject to Section 1 of this Act, which shall include assuming any liabilities established in that section; and***

3. a. Within ten (10) days of an executed contract, ensure that any internal processing systems of the managed care organization have been updated to include:

i. The accepted provider contract; and

ii. The provider as a participating provider.

b. In the event that the loading and configuration of a contract with a provider will take longer than ten (10) days, the managed care organization may take an additional fifteen (15) days if it has notified the provider of the need for additional time.

(5) ~~[(a)]~~Nothing in this section ***shall be construed to:*** ~~[requires]~~

(a) Require a Medicaid managed care organization to contract with a provider if the managed care organization and the provider do not agree on the terms and conditions for participation***; or*** ~~[.]~~

(b) ~~[Nothing in this section shall]~~Prohibit a provider and a managed care organization from negotiating the terms of a contract prior to the completion of the department's enrollment and screening process.

(6) (a) For the purpose of reimbursement of claims, once a provider has met the terms and conditions for credentialing and enrollment, the provider's credentialing application date shall be the date from which the provider's claims become eligible for payment.

(b) A Medicaid managed care organization shall not require a provider to appeal or resubmit any clean claim submitted during the time period between the provider's credentialing application date and a managed care organization's completion of its credentialing process.

(c) Nothing in this section shall limit the department's authority to establish criteria that allow a provider's claims to become eligible for payment in the event of lifesaving or life-preserving medical treatment, such as, for an

illustrative but not exclusive example, an organ transplant.

(7) Nothing in this section shall prohibit a university hospital, as defined in KRS 205.639, from performing the activities of a credentialing verification organization for its employed physicians, residents, and mid-level practitioners where such activities are delineated in the hospital's contract with a Medicaid managed care organization. The provisions of subsections (3), (4), (5), and (6) of this section with regard to payment and timely action on a credentialing application shall apply to a credentialing application that has been verified through a university hospital pursuant to this subsection.

(8) To promote seamless integration of licensure information, the relevant provider licensing boards in Kentucky are encouraged to forward and provide licensure information electronically to the department and any credentialing verification organization.

➔Section 3. KRS 304.17A-700 is amended to read as follows:

As used in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123:

(1) "Adjudicate" means an insurer pays, contests, or denies a clean claim;

(2) "Claims payment time frame" means the time period prescribed under KRS 304.17A-702 following receipt of a clean claim from a provider at the address published by the insurer, whether it is the address of the insurer or a delegated claims processor, within which an insurer is required to pay, contest, or deny a health care claim;

(3) "Clean claim" means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:

(a) A clean claim from an institutional provider shall consist of:

1. The UB-92 data set or its successor submitted on the designated paper or

electronic format as adopted by the NUBC;

2. Entries stated as mandatory by the NUBC; and

3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

(b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.

(c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.

(d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

(4) "Commissioner" means the commissioner of the Department of Insurance;

(5) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services;

(6) "Department" means the Department of Insurance;

(7) "Electronic" or "electronically" means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;

(8) "Health benefit plan" has the same meaning as provided in KRS 304.17A-005;

(9) "Health care provider" or "provider" means a provider licensed in Kentucky as defined in KRS 304.17A-005 and, for the purposes of KRS 304.17A-700 to 304.17A-730 and KRS 205.532, 205.593, 304.14-135,~~[and]~~ 304.99-123 ***and Section 1 of this Act*** only, shall include physical therapists licensed under KRS Chapter 327, psychologists licensed under KRS Chapter 319, and social workers licensed under KRS Chapter 335. Nothing contained in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall be construed to

include physical therapists, psychologists, and social workers as a health care provider or provider under KRS 304.17A-005;

(10) "Health claim attachments" means medical information from a covered person's medical record required by the insurer containing medical information relating to the diagnosis, the treatment, or services rendered to the covered person and as may be required pursuant to KRS 304.17A-720;

(11) "Institutional provider" means a health care facility licensed under KRS Chapter 216B;

(12) "Insurer" has the same meaning provided in KRS 304.17A-005;

(13) "Kentucky Uniform Billing Committee (KUBC)" means the committee of health care providers, governmental payors, and commercial insurers established as a local arm of NUBC to implement the bill requirements of the NUBC and to prescribe any additional billing requirements unique to Kentucky insurers;

(14) "National Uniform Billing Committee (NUBC)" means the national committee of health care providers, governmental payors, and commercial insurers that develops the national uniform billing requirements for institutional providers as referenced in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, secs. 300gg et seq.;

(15) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person; and

(16) "Utilization review" has the same meaning as provided in KRS 304.17A-600.

➔Section 4. Whereas the ability of health care providers to provide health care services to Kentucky citizens that satisfy the minimum standards of professional care is largely dependent on contracts the providers enter with insurers, and whereas the ability of providers to engage in good faith and equitable negotiations with insurers to provide health care services that satisfy the minimum standards of professional care is essential to ensuring the health and welfare of Kentucky citizens, an emergency is declared to exist,

and this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming a law.