AN ACT relating to the prompt payment of Medicaid claims and declaring an emergency.

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:

A Medicaid managed care organization shall measure distance using road miles and travel time based on average speed, road conditions, and type of road.

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

As used in Sections 2 and 3 of this Act:

(1) "Activities compliant with 42 C.F.R. sec. 438.608" means Medicaid managed care organization expenditures on activities related to the program integrity requirements in 42 C.F.R. sec. 438.608(a)(1) to (5), (7), and (8) and (b), limited to one-half of one percent (0.5%) of premium revenue. Expenditures under this subsection shall not include expense for fraud reduction efforts in 42 C.F.R. sec. 438.8(e)(2)(iii)(C);

(2) "Activities that improve health care quality" shall be in one (1) of the following categories:

(a) A Medicaid managed care activity that meets the requirements of 45 C.F.R. sec. 158.150(b) and is not excluded under 45 C.F.R. sec. 158.150(c);

(b) A Medicaid managed care organization activity related to any external quality review organization activity as described in 42 C.F.R. sec. 438.358(b) and (c);

(c) Any Medicaid managed care expenditure that is related to health information technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. sec. 158.151, and is not considered incurred claims as defined in this section; or

(d) An expenditure that is warranted as appropriate pursuant to a statutory provision;

(3) "Adjusted premium revenue" means a Medicaid managed care organization's premium revenue minus the Medicaid managed care organizations federal and state taxes and licensing and regulatory fees and is aggregated in accordance with this section 2 of this Act;

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

(5) "Federal and state taxes and licensing and regulatory fees" means taxes, licensing, and regulatory fees for the medical loss ratio reporting year which include:

(a) Statutory assessments to defray the operating expenses of any state or federal department;

(b) Examination fees in lieu of premium taxes as specified by state law;

(c) Federal taxes and assessments allocated to Medicaid managed care organizations, including federal income taxes on investment income and capital gains and federal employment taxes; or

(d) State taxes and assessments including:

1. Any industrywide, or subset, assessments, other than surcharges on specific claims, paid to the state directly;

2. Guaranty fund assessments;

3. Assessments of state industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by states;

4. State income, excise, and business taxes other than premium taxes and state employment and similar taxes and assessments;

5. State premium taxes plus state taxes based on reserves, if in lieu of premium taxes; or

6. Payments made by a Medicaid managed care organization which are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 C.F.R. sec. 158.162(c), limited to the highest of either:

a. Three percent (3%) of earned premium; or

b. The highest premium tax rate in the state for which the report is being submitted, multiplied by the Medicaid managed care organization's earned premium in the state;

(6) "Incurred claims" means:

(a) 1. a. Direct claims that the Medicaid managed care organization paid to providers or members or enrollees, including those under capitated contracts with network providers, for services or supplies covered under the contract and medical services provided to enrollees under the Medicaid managed care organization's approved contract;

b. Unpaid claims reserves for the medical loss ratio reporting year, including claims reported in the process of adjustment;

c. Withholds from payments made to network providers;

d. Claims that are recoverable for anticipated coordination of benefits;

e. Claims payment recoveries received as a result of subrogation;

f. Incurred but not reported claims based on past experience and modified to reflect current conditions such as changes in exposure, claim frequency, or severity;

g. Changes in other claims-related reserves; or

h. Reserves for contingent benefits and the medical claim portion of lawsuits;

2. Amounts that must be deducted from incurred claims which include the following:

a Overpayment recoveries received from health care professionals;

b. Prescription drug rebates received by the Medicaid managed care organization; or

c. State subsidies based on a stop loss payment methodology; and

3. Expenditures that must be included in incurred claims, including the following:

a. Payments made by a Medicaid managed care organization to mandated solvency funds;

b. The amount of incentive and bonus payments made to network providers; and

c. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses shall not include activities compliant with 42 C.F.R. sec. 438.608.

(b) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to risk adjustment and risk corridor programs developed in accordance with 42 C.F.R. sec. 438.5 or 438.6.

(c) Amounts that shall be excluded from incurred claims include:

1. Non-claims costs, which include:

a. Amounts paid to third-party vendors for secondary network savings;

b. Amounts paid to third-party vendors for network development, administrative fees, claims processing, and utilization management;

c. Amounts paid, including amounts paid to a health care professional, for professional or administrative services that do not represent compensation or reimbursement for state plan services or services meeting the definition in 42 C.F.R. sec. 438.3(e) and provided to an enrollee; or

d. Fines and penalties assessed by regulatory authorities; and

2. Amounts paid to the state as remittance under this subsection.

(6) "Member months" means the number of months an enrollee is covered by a Medicaid managed care organization over a specified time period such as a year;

(7) "Medical loss ratio reporting year" means a state fiscal year beginning in state fiscal year 2016-2017;

(8) "Non-claims cost" means those expenses for administrative services that are not incurred claims, expenditures on quality improving activities, licensing and regulatory fees, or federal and state taxes; and

(9) "Premium revenue" includes the following for the medical loss ratio reporting year:

(a) State capitation payments for all enrollees under a risk contract;

(b) State developed one (1) time payments for specific life events of enrollees;

(c) Other payments to the Medicaid managed care organization under the contract approved under 42 C.F.R. sec. 438.6, such as incentive arrangement payments or withhold payments;

(d) Unpaid cost-sharing amounts that the Medicaid managed care organization can show it made a reasonable but unsuccessful effort to collect; or

(e) All changes to unearned premium reserves.

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

(1) Beginning in state fiscal year 2016-2017, and annually thereafter, a Medicaid

managed care organization shall calculate and report a medical loss ratio in accordance with Sections 2 and 3 of this Act as long as these requirements supplement, but do not contradict, the definitions or requirements of federal law.

(2) The minimum medical loss ratio for a Medicaid managed care organization shall be equal to or higher than eighty-five percent (85%) in each year.

(3) (a) The medical loss ratio experienced for each Medicaid managed care organization in a reporting year is the ratio of the numerator to the denominator.

(b) The numerator of a Medicaid managed care organization for a medical loss ratio reporting year is the sum of the Medicaid managed care organizations incurred claims, expenditures for activities that improve health care quality, and activities compliant with 42 C.F.R. sec. 438.608.

(c) For a medical loss ratio reporting year, the denominator of the medical loss ratio shall equal the adjusted premium revenue. The total amount of the denominator for a Medicaid managed care organization which is later assumed by another entity shall be reported by the assuming Medicaid managed care organization for the entire medical loss ratio reporting year and no amount under this paragraph for that year may be reported by the ceding Medicaid managed care organization.

(d) 1. Each expense shall be included under only one (1) type of expense unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense shall be prorated between types of expenses;

2. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on a pro rata basis.

3. Allocation of expenses to each category shall be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract shall be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to the other entities.

(4) Each Medicaid managed care organization shall provide a remittance for a medical loss ratio reporting year if the medical loss ratio for that year does not meet the minimum medical loss ratio standard of eight-five percent (85%) or higher. Remittance shall be made no later than March of the following calendar year.

(5) (a) Each Medicaid managed care organization shall submit and attest to the accuracy of the data contained in a report to the department that includes at least the following information for each medical loss ratio reporting year:

1. Total incurred claims;

2. Expenditures on quality-improving activities;

3. Expenditures related to activities compliant with 42 C.F.R. sec. 438.608;

4. Non-claims costs;

5. Premium revenue;

6. Taxes, licensing, and regulatory fees;

7. Methodology for allocation of expenditures;

8. Any credibility adjustment applied;

9. The calculated medical loss ratio;

10. Any remittance owed to the Commonwealth, if applicable;

11. A reconciliation of the information reported in this paragraph with the audited financial required under 42 C.F.R. sec. 438.3(m);

12. A description of the aggregation method used under subparagraph 3. of this paragraph; or

13. The number of member months.

(b) A Medicaid managed care organization shall submit the report required in this subsection in a timeframe and manner as prescribed by the department which must be within twelve (12) months after the end of the medical loss ratio reporting year.

(c) A Medicaid managed care organization shall aggregate data for all Medicaid eligibility groups covered under the contract with the Commonwealth unless the department prescribed separate reporting for specific populations.

(d) Incurred claims paid by one (1) Medicaid managed care organization that is later assumed by another entity shall be reported by the assuming Medicaid managed care organization for the entire medical loss ratio reporting year and no incurred claims for that medical loss ratio reporting year may be reported by the ceding Medicaid managed care organization.

(6) In any instance where the department makes a retroactive change to the capitation payments for a medical loss ratio reporting year where the report has already been submitted to the department, a Medicaid managed care organization shall recalculate the medical loss ratio for all medical loss ratio reporting years affected by the change and submit a new report meeting the requirements in subsection (5) of this section.

(7) A Medicaid managed care organization shall not provide bonus or incentive payments to contracted providers or subcontractors which are determined based upon whether or not the Medicaid managed care organization meets or exceeds

the medical loss ratio in a medical loss ratio reporting year.

(8) A Medicaid managed care organization shall prepare and submit to the department supplemental financial schedules as prescribed by the department to reconcile medical expenses reported on the annual statement required by the Kentucky Department of Insurance to medical expenses reported to the department for purposes of the medical loss ratio calculation. These supplemental schedules shall be submitted to the department thirty (30) calendar days after the report required under subsection (5) of this section is required to be submitted. The department shall determine within thirty (30) days whether any adjustment is to be collected. If an additional payment is due, a Medicaid managed care organization shall have thirty (30) days to review the department's findings and remit payment. The annual statement and supplemental schedules shall be audited by an independent accounting firm contracted by the Commonwealth.

➔Section 4. KRS 304.17A-730 is amended to read as follows:

(1) An insurer that fails to pay, deny, or settle a clean claim in accordance with KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall pay interest according to the following schedule on the amount of the claim that remains unpaid:

(a) For claims that are paid between one (1) and thirty (30) days from the date that payment was due under KRS 304.17A-702, interest at a rate of twelve percent (12%) per annum shall accrue from the date payment was due under KRS 304.17A-702;

(b) For claims that are paid between thirty-one (31) and sixty (60) days from the date that payment was due under KRS 304.17A-702, interest at a rate of eighteen percent (18%) per annum shall accrue from the date payment was due under KRS 304.17A-702; and

(c) For claims that are paid more than sixty (60) days from the date payment was due under KRS 304.17A-702, interest at a rate of twenty-one percent (21%) per annum shall accrue from the date that payment was due under KRS 304.17A-702.

(2) When paying a claim after the time required by KRS 304.17A-702, the insurer shall add the interest payable to the amount of the unpaid claim without the necessity for any claim for that interest to be made by the provider filing the original claim. The interest obligation otherwise imposed by this section shall not apply if the failure to pay, deny, or settle a claim is due to, or results from, in whole or in part, acts or events beyond the control of the insurer, including but not limited to acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbance, riot, or complete or partial disruptions of facilities.

(3) (a) The commissioner of the Department of Insurance shall enforce the provisions of KRS 304.17A-700 to 304.17A-730, 205.593, 304.14-135, and 304.99-123 regarding the payment of health care claims by any health care provider rendering services for any provider partnership, health maintenance organization, or other managed care organization under contract with the Department for Medicaid Services to manage care and process health care claims for services delivered to Medicaid recipients covered under Medicaid managed care.

(b) 1. Any health care provider rendering services to a Medicaid recipient may file a complaint with the Department of Insurance for a failure to comply with prompt payment provisions:

a. Under the terms of the contract between:

i. A Medicaid managed care organization and a provider; or

ii. A Medicaid managed care organization and a member; or

b. Under KRS 304.17A-700 to 304.17A-730 or 304.14-135;

by any provider partnership, health maintenance organization, or other managed care organization under contract with the Department for Medicaid Services to manage care and process health care claims for services delivered to Medicaid recipients covered under Medicaid managed care.

2. A hearing may be requested for a claim designated "clean" but unpaid for thirty (30) or more days:

a. When the claim is denied; or

b. Thirty (30) days after the claim is submitted by a provider.

3. a. A hearing may be requested for a claim designated "less than clean" or otherwise subject to delay of payment by a Medicaid managed care company after nonpayment for one hundred twenty (120) days.

b. A Medicaid managed care company shall acknowledge the request for a hearing and within five (5) business days shall notify the provider, its billing agent, or designee that submitted the claim, in writing or electronically, of all information that is missing from the billing instrument, any errors in the billing instrument, or of any other circumstances which preclude it from being a clean claim.

4. A provider with more than one (1) denied claim for identical or similar services may request review of multiple claims in the same review process.

5. The Department of Insurance may charge a reasonable filing fee and a reasonable fee for management of the claim to offset its reasonable expenses in administering a hearing.

6. a. The Department of Insurance may investigate any issues

identified as a result of a report, investigation, or hearing conducted under this subsection or subsection (4) of this section.

b. An eligible claim shall be filed with the Department of Insurance within thirty (30) days of becoming eligible under this paragraph or paragraph (c) of this subsection.

c. The Department of Insurance shall make a determination concerning whether a claim should be paid or not within thirty (30) days if no hearing is requested and within sixty (60) days if a hearing is requested.

7. The Department of Insurance and the Department for Medicaid Services are encouraged to forward any reporting documents utilized under this subsection or subsection (4) of this section to the Office of the State Auditor for review.

8. No provision of this subsection or subsection (4) of this section shall impact the claims payment or dispute procedures that relate to a fee-for-service Medicaid program administered by the cabinet.

(c) An interest rate of fourteen percent (14%) may be awarded after an administrative hearing and review on claims found to be unpaid in violation of:

1. The contract between the Medicaid managed care company and the Commonwealth;

2. A contract between the Medicaid managed care company and the provider;

3. A contract between the Medicaid managed care company and the member;

4. This subsection or subsection (4) of this section;

5. KRS 304.17A-700 to 304.17A-730; or

6. KRS 205.593.

(d) 1. The Department of Insurance's authority to enforce subsection (1) of this section shall include the authority to assess a fine of no more than one hundred dollars ($100) per violation when a Medicaid managed care company fails to comply with this section or KRS 304.17A-700 to 304.17A-730, 205.593, or 304.14-135.

2. Each day that a Medicaid managed care company fails to comply with this section or KRS 304.17A-700 to 304.17A-730, 205.593, or 304.14-135 shall count as a separate violation.

(4) (a) The commissioner of the Department of Insurance shall enforce the provisions of KRS 304.17A-700 to 304.17A-730, 205.593, 304.14-135, and 304.99-123 regarding the payment of health benefit claims to any health care provider rendering services to Medicaid recipients for the Department for Medicaid Services through a managed care organization under contract with the Commonwealth.

(b) Within sixty (60) days of the effective date of this Act, the Department of Insurance shall promulgate administrative regulations in accordance with KRS Chapter 13A to establish, implement, and operate by September 1, 2016, the internal appeals and hearing process for review of prompt payment claims under this section. Any administrative process conducted under this section shall be conducted in accordance with KRS Chapter 13B, except that any process established pursuant to this subsection shall guarantee the following:

1. The proper venue for an appeal following an administrative hearing or ruling shall be with the Franklin Circuit Court;

2. A claimant and the Medicaid managed care company may appear in person or through a designee to present evidence at the hearing;

3. The claimant and the Medicaid managed care company may subpoena witnesses, including expert witnesses, for the hearing; and

4. The hearing officer may request provision of evidence or appearance by witnesses and may subpoena relevant witnesses and evidence for the purposes of hearing and review.

➔Section 5. KRS 304.17A-722 is amended to read as follows:

(1) ~~[No later than ninety (90) days following July 15, 2002,]~~The department shall promulgate administrative regulations requiring all insurers to report information on a calendar quarter basis on prompt payment of claims to providers, as defined in KRS 304.17A-700, that shall be limited to the following:

(a) ***1.*** The number of ***original***~~[clean]~~ claims received by the insurer, its agent, or designee during the reporting period ***from a provider, its billing agent, or designee***; ***and***

2. The number of corrected claims received by the insurer, its agent, or designee during the reporting period from a provider, its billing agent, or designee including the number of times the corrected claim has been previously submitted to the insurer, its agent, or designee;

(b) The ***number and*** percentage of clean claims received by the insurer, its agent, or designee that were:

1. Adjudicated within the claims payment timeframe;
2. Adjudicated within one (1) to thirty (30) days from the end of the claims payment timeframe;
3. Adjudicated within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe;
4. Adjudicated within sixty-one (61) to ninety (90) days from the end of the claims payment timeframe;
5. Adjudicated more than ninety (90) days from the end of the claims

payment timeframe; and

6. Not yet adjudicated;

(c) The ***number and*** percentage of clean claims received during the reporting quarter that were paid and not denied or contested:

1. Within the claims payment timeframe;
2. Within one (1) to thirty (30) days from the end of the claims payment timeframe;
3. Within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe;
4. Within sixty (60) to ninety (90) days from the end of the claims payment timeframe;
5. More than ninety (90) days from the end of the claims payment timeframe; and
6. Not yet paid;

(d) Amount of interest paid; and

(e) For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount ***and the number*** of those claims that were paid within the claims payment timeframe.

(2) Data required in subsection (1) of this section shall be reported for hospitals, physicians, and all other providers, excluding pharmacies.

(3) ***The department shall promulgate administrative regulations requiring all insurers and entities that contract with insurers to provide pharmacy claims administration to report on a calendar quarter basis on payment of pharmacy claims.***

(4) Insurers shall submit information required in subsection (1) of this section to the department no later than ***ninety (90)***~~[one hundred eighty (180)]~~ days following the close of the reporting quarter.

(5)~~[(4)]~~ The department shall, as part of the market conduct survey of each insurer, audit the insurer to determine compliance with KRS 304.17A-700 to 304.17A-730 and KRS 304.14-135 and 304.99-123. Findings shall be made available to the public upon request.

(6)~~[(5)]~~ The commissioner shall annually present to the Interim Joint Committee on Banking and Insurance and to the Governor a report on the payment practices of insurers and compliance with the provisions of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 and the commissioner's enforcement activities, including the number of complaints received and those acted upon by the department.

➔Section 6. Those claims that are currently eligible for a hearing under Section 4 of this Act and any claims that become eligible after the effective date of this Act and before the implementation of administrative regulations to govern the hearing process established in Section 4 of this Act shall be guaranteed interest under subsection (3)(c) of Section 4 of this Act and each day of nonpayment shall be eligible as a separate violation under subsection (3)(d) of Section 4 of this Act.

➔Section 7. This Act applies to all contracts between Medicaid managed care organizations and the Department for Medicaid Services entered into or renewed on or after July 1, 2016.

➔Section 8. Whereas the effective administration of the Medicaid program is of tantamount importance to the Commonwealth, an emergency is declared to exist and this Act takes effect July 1, 2016.