

1 AN ACT relating to Medicaid, making an appropriation therefor, and declaring an  
2 emergency.

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

4 → Section 1. KRS 205.5371 is amended to read as follows:

5 (1) **(a)** The cabinet~~[, to the extent permitted under federal law,]~~ shall, **no later than**  
6 **January 1, 2027, for applicable individuals as defined in 42 U.S.C. sec.**  
7 **1396a(xx)(9), condition eligibility for enrollment or continued enrollment in**  
8 **the Medicaid program on demonstrated community engagement as defined**  
9 **in and required under 42 U.S.C. sec. 1396a(xx)**~~[ implement a mandatory~~  
10 ~~community engagement waiver program for able-bodied adults without~~  
11 ~~dependents who have been enrolled in the state's medical assistance program~~  
12 ~~for more than twelve (12) months].~~

13 **(b)** **In the case of an applicable individual who is applying for enrollment in the**  
14 **Medicaid program, in order to be eligible for enrollment the individual shall**  
15 **be required to demonstrate community engagement for the month**  
16 **immediately preceding the month during which the individual applies for**  
17 **enrollment.**

18 **(c)** **In the case of an applicable individual who is enrolled and receiving**  
19 **Medicaid benefits, in order to remain eligible for continued enrollment, at**  
20 **the time of eligibility redetermination, the individual shall be required to**  
21 **demonstrate community engagement for three (3) consecutive months**  
22 **during the period of time since the individual's most recent eligibility**  
23 **determination or redetermination.**

24 (2) **Notwithstanding any provision of state law to the contrary, the cabinet shall not**  
25 **request an exemption, waiver, or any other delay, including but not limited to a**  
26 **good-faith-effort exemption, in implementing the requirements of 42 U.S.C. sec.**  
27 **1396a(xx) or subsection (1) of this section that may be available to the state under**

1 42 U.S.C. sec. 1396a(xx)(11) unless specifically authorized by the General  
 2 Assembly to do so~~[If the federal Centers for Medicare and Medicaid Services~~  
 3 ~~approves the implementation of a mandatory community engagement waiver~~  
 4 ~~program pursuant to subsection (1) of this section:~~

5 (a) ~~The program may, for the purpose of defining qualifying community~~  
 6 ~~engagement activities, utilize the same requirements established in 7 C.F.R.~~  
 7 ~~sec. 273.24;~~

8 (b) ~~Participation in the job placement assistance program established in KRS~~  
 9 ~~151B.420 shall constitute qualifying community engagement activities; and~~

10 (c) ~~The cabinet shall, on a monthly basis, provide the Education and Labor~~  
 11 ~~Cabinet with the name and contact information of each individual~~  
 12 ~~participating in the community engagement program].~~

13 (3) ~~[(a)]~~ ***The cabinet shall begin, no later than September 1, 2026, providing notice***  
 14 ***to all applicable individuals, as defined in 42 U.S.C. sec. 1396a(xx)(9), of the***  
 15 ***requirement to demonstrate community engagement as established under 42***  
 16 ***U.S.C. sec. 1396a(xx) and subsection (1) of this section. Notice provided under***  
 17 ***this subsection shall comply with the requirements of 42 U.S.C. sec.***  
 18 ***1396a(xx)(8)***~~[The cabinet is hereby authorized, as is required under KRS 205.5372,~~  
 19 ~~and is directed to submit a waiver application to the Centers for Medicare and~~  
 20 ~~Medicaid Services requesting approval to establish the mandatory community~~  
 21 ~~engagement waiver program for able-bodied adults without dependents described in~~  
 22 ~~subsections (1) and (2) of this section within ninety (90) days after March 27, 2025.~~

23 (b) ~~As required in KRS 205.525, the cabinet shall provide a copy and summary of~~  
 24 ~~the waiver application submitted pursuant to this section to the Legislative~~  
 25 ~~Research Commission for referral to the Medicaid Oversight and Advisory~~  
 26 ~~Board, the Interim Joint Committee on Appropriations and Revenue, and the~~  
 27 ~~Interim Joint Committee on Health Services concurrent with submitting the~~

1 application to the Centers for Medicare and Medicaid Services and shall  
2 provide an update on the status of the application at least quarterly].

3 (4) **If at any time on or after the effective date of this Act, the federal community**  
4 **engagement requirements established in 42 U.S.C. sec. 1396a(xx) are abolished,**  
5 **repealed, or otherwise diminished, the cabinet shall:**

6 **(a) Immediately prepare and submit a waiver application to the federal Centers**  
7 **for Medicare and Medicaid Services seeking authorization to condition the**  
8 **eligibility of applicable individuals, as defined in subsection (5) of this**  
9 **section, to enroll or continue to be enrolled in the Medicaid program on**  
10 **demonstrated community engagement, as defined in subsection (5) of this**  
11 **section; and**

12 **(b) For applicable individuals, as defined in subsection (5) of this section, and**  
13 **in accordance with subsections (1)(b) and (c) of this section, condition**  
14 **eligibility for enrollment or continued enrollment in the Medicaid program**  
15 **on demonstrated community engagement, as defined in subsection (5) of**  
16 **this section, if authorized to do so by the federal Centers for Medicare and**  
17 **Medicaid Services.**

18 **(5) As used in subsection (4) of this section**[this section, "able-bodied adult without  
19 dependents" means an individual who is]:

20 (a) **"Applicable individual" means an individual who is:**[Over eighteen (18)  
21 years of age but under sixty (60) years of age;]

22 **1. At least nineteen (19) years of age but less than sixty-five (65) years of**  
23 **age;**

24 **2. Eligible for enrollment or currently enrolled in the Medicaid program**  
25 **under 42 U.S.C. sec. 1396a(a)(10)(A)(i)(VIII) or a waiver that**  
26 **provides coverage that is equivalent to minimum essential coverage as**  
27 **described in Section 5000A(f)(1)(A) of the Internal Revenue Code of**

1                   1986; and

2           3. Not:

3           a. Currently, or was not previously, placed in the foster care system  
 4           if the individual is under twenty-six (26) years of age;

5           b. Eligible for coverage under the Indian Health Service;

6           c. A parent, guardian, caretaker relative, or family caregiver, as  
 7           defined in the RAISE Family Caregivers Act, Pub. L. No. 115-  
 8           119, of a dependent child thirteen (13) years of age or under or a  
 9           disabled individual;

10          d. A disabled veteran with a disability rated as total under 38 U.S.C.  
 11          sec. 1155;

12          e. Medically frail or otherwise has special medical needs, including  
 13          an individual:

14           i. Who is blind or disabled;

15           ii. With a substance use disorder;

16           iii. With a disabling mental condition;

17           iv. With a physical, intellectual, or developmental disability  
 18           that significantly impairs his or her ability to perform one  
 19           (1) or more activities of daily living; or

20           v. With a serious or complex medical condition;

21          f. An individual subject to work or community engagement  
 22          requirements imposed under the Supplemental Nutrition  
 23          Assistance Program or Temporary Assistance for Needy  
 24          Families, if the individual is in compliance with such  
 25          requirements;

26          g. An individual participating in a drug addiction or alcohol  
 27          addiction recovery program recognized by the secretary through

1                   the promulgation of administrative regulations in accordance  
 2                   with KRS Chapter 13A;

3                   h. An inmate at a public institution;

4                   i. Pregnant or eligible for coverage under KRS 205.592; or

5                   j. An individual experiencing a short-term hardship as defined by  
 6                   the secretary through the promulgation of administrative  
 7                   regulations in accordance with KRS Chapter 13A; and

8                   (b) "Demonstrated community engagement" means satisfying one (1) or more  
 9                   of the following conditions on a monthly basis:

10                   1. Working, as defined in 7 C.F.R. sec. 273.24, not less than eighty (80)  
 11                   hours;

12                   2. Completing not less than eighty (80) hours of community service;

13                   3. Participating in a work program, as defined in 7 C.F.R. sec. 273.24,  
 14                   for not less than eighty (80) hours;

15                   4. Participating at least half-time in an education program recognized by  
 16                   the secretary through the promulgation of administrative regulations  
 17                   in accordance with KRS Chapter 13A;

18                   5. Engaging in any combination of activities described in subparagraphs  
 19                   1., 2., 3., and 4. of this paragraph for a total of not less than eighty  
 20                   (80) hours;

21                   6. Having a verifiable monthly income that is not less than applicable  
 22                   state minimum wage established in KRS 337.275 multiplied by eighty  
 23                   (80) hours; or

24                   7. Having a verifiable average monthly income over the previous six (6)  
 25                   months that is not less than applicable state minimum wage  
 26                   established in KRS 337.275 multiplied by eighty (80) hours if the  
 27                   individual is a seasonal worker as described in Section 45R(d)(5)(B) of

1 *the Internal Revenue Code of 1986*

2 ~~(b) Physically and mentally able to work as determined by the cabinet; and~~

3 ~~(c) Not primarily responsible for the care of a dependent child under the age of~~  
 4 ~~eighteen (18) or a dependent disabled adult relative].~~

5 → Section 2. KRS 205.6312 is amended to read as follows:

6 *(1) The Department for Medicaid Services and each managed care organization*  
 7 *contracted by the department to provide Medicaid services pursuant to this*  
 8 *chapter shall establish cost-sharing requirements for Medicaid enrollees in*  
 9 *accordance with this section*~~[Notwithstanding any state law to the contrary, the~~

10 ~~cabinet or a managed care organization contracted by the cabinet to provide~~  
 11 ~~Medicaid services pursuant to this chapter shall not institute copayments, cost~~  
 12 ~~sharing, or similar charges to be paid by any medical assistance recipients, their~~  
 13 ~~spouses, or parents, for any assistance provided pursuant to this chapter, federal~~  
 14 ~~law, or any federal Medicaid waiver].~~

15 *(2) Unless otherwise required under federal law, including 42 U.S.C. sec. 1396o(k),*  
 16 *cost-sharing requirements established under this section shall only apply to*  
 17 *Medicaid enrolled individuals:*

18 *(a) With a family income that exceeds one hundred percent (100%) of the*  
 19 *federal poverty line; and*

20 *(b) Who are enrolled in the Medicaid program under 42 U.S.C. sec.*  
 21 *1396a(a)(10)(A)(i)(VIII).*

22 *(3) In accordance with 42 U.S.C. sec. 1396o(k)(2)(B)(i), the following services shall*  
 23 *not be subject to cost-sharing requirements established under this section unless*  
 24 *otherwise required by federal law:*

25 *(a) Any care, item, or service described in 42 U.S.C. sec. 1396o(a)(2)(B) et seq.;*

26 *(b) Primary care services;*

27 *(c) Mental health care services;*

1 (d) Substance use disorder services;

2 (e) Any services provided by a:

3 1. Federally-qualified health center, as defined in 42 U.S.C. sec.

4 1396d(l)(2);

5 2. Certified community behavioral health clinic, as defined in 42 U.S.C.

6 sec. 1396d(jj)(2); or

7 3. Rural health clinic, as defined in 42 U.S.C. sec. 1396d(l)(1); and

8 (f) Any other service exempted from cost-sharing requirements under federal

9 law.

10 (4) (a) Except as provided in paragraph (b) of this subsection and subsections (3)

11 and (5) of this section, beginning October 1, 2028, for care or an item or

12 service furnished to a Medicaid enrolled individual described in subsection

13 (2) of this section, the cost-sharing requirement established under this

14 subsection shall be in the form of a copayment requirement equal to five

15 dollars (\$5).

16 (b) The cost-sharing requirements established under this subsection for any

17 prescription drugs shall be in the form of a copayment requirement equal to

18 one dollar (\$1).

19 (5) The total aggregate amount of cost sharing imposed under this section for all

20 individuals in a family shall not exceed five percent (5%) of the family's income

21 on a monthly or quarterly basis, as determined by the secretary.

22 → Section 3. KRS 205.556 is amended to read as follows:

23 (1) As used in this section:

24 (a) "Breast pump kit" means a collection of tubing, valves, flanges, bottles, and  
25 other parts required to extract human milk using a breast pump;

26 (b) "In-home program" means a program offered by a health care facility or  
27 health care professional for the treatment of substance use disorder which the

1 insured accesses through telehealth or digital health service;

2 (c) "Lactation consultation" means the clinical application of scientific principles  
3 and a multidisciplinary body of evidence for evaluation, problem  
4 identification, treatment, education, and consultation to families regarding the  
5 course of lactation and feeding by a qualified clinical lactation care  
6 practitioner, including but not be limited to:

- 7 1. Clinical maternal, child, and feeding history and assessment related to  
8 breastfeeding and human lactation through the systematic collection of  
9 subjective and objective information;
- 10 2. Analysis of data;
- 11 3. Development of a lactation management and child feeding plan with  
12 demonstration and instruction to parents;
- 13 4. Provision of lactation and feeding education;
- 14 5. The recommendation and use of assistive devices;
- 15 6. Communication to the primary health care practitioner or practitioners  
16 and referral to other health care practitioners, as needed;
- 17 7. Appropriate follow-up with evaluation of outcomes; and
- 18 8. Documentation of the encounter in a patient record;

19 (d) "Qualified clinical lactation care practitioner" means a licensed health care  
20 practitioner wherein lactation consultation is within their legal scope of  
21 practice; and

22 (e) "Telehealth" or "digital health" has the same meaning as in KRS 211.332.

23 (2) The Department for Medicaid Services and any managed care organization with  
24 which the department contracts for the delivery of Medicaid services shall provide  
25 coverage:

26 (a) For lactation consultation;

27 (b) For breastfeeding equipment;

- 1 (c) To pregnant and postpartum women for an in-home program; and
- 2 (d) For telehealth or digital health services that are related to maternity care
- 3 associated with pregnancy, childbirth, and postpartum care.
- 4 (3) The coverage required by this section shall:
- 5 (a) Not be subject to:
- 6 1. Any cost-sharing requirements, including but not limited to copayments,
- 7 *unless otherwise required under federal law*; or
- 8 2. Utilization management requirements, including but not limited to prior
- 9 authorization, prescription, or referral, except as permitted in paragraph
- 10 (d) of this subsection;
- 11 (b) Be provided in conjunction with each birth for the duration of breastfeeding,
- 12 as defined by the beneficiary;
- 13 (c) For lactation consultation, include:
- 14 1. In-person, one-on-one consultation, including home visits, regardless of
- 15 location of service provision;
- 16 2. The delivery of consultation via telehealth, as defined in KRS 205.510,
- 17 if the beneficiary requests telehealth consultation in lieu of in-person,
- 18 one-on-one consultation; or
- 19 3. Group consultation, if the beneficiary requests group consultation in lieu
- 20 of in-person, one-on-one consultation; and
- 21 (d) For breastfeeding equipment, include:
- 22 1. Purchase of a single-user, double electric breast pump, or a manual
- 23 pump in lieu of a double electric breast pump, if requested by the
- 24 beneficiary;
- 25 2. Rental of a multi-user breast pump on the recommendation of a licensed
- 26 health care provider; and
- 27 3. Two (2) breast pump kits as well as appropriately sized breast pump

1 flanges and other lactation accessories recommended by a health care  
2 provider.

3 (4) (a) The breastfeeding equipment described in subsection (3)(d) of this section  
4 shall be furnished within forty-eight (48) hours of notification of need, if  
5 requested after the birth of the child, or by the later of two (2) weeks before  
6 the beneficiary's expected due date or seventy-two (72) hours after  
7 notification of need, if requested prior to the birth of the child.

8 (b) If the department cannot ensure delivery of breastfeeding equipment in  
9 accordance with paragraph (a) of this subsection, an individual may purchase  
10 equipment and the department or a managed care organization with whom the  
11 department contracts for the delivery of Medicaid services shall reimburse the  
12 individual for all out-of-pocket expenses incurred by the individual, including  
13 any balance billing amounts.

14 → Section 4. KRS 205.618 is amended to read as follows:

15 (1) Notwithstanding any provision of law to the contrary, the Department for Medicaid  
16 Services or a managed care organization contracted to provide Medicaid services  
17 shall, at a minimum, provide coverage for all United States Food and Drug  
18 Administration-approved tobacco cessation medications, all forms of tobacco  
19 cessation services recommended by the United States Preventive Services Task  
20 Force, including but not limited to individual, group, and telephone counseling, and  
21 any combination thereof.

22 (2) The following conditions shall not be imposed on any tobacco cessation services  
23 provided pursuant to this section:

24 (a) Counseling requirements for medication;

25 (b) Limits on the duration of services, including but not limited to annual or  
26 lifetime limits on the number of covered attempts to quit; or

27 (c) Copayments or other out-of-pocket cost sharing, including deductibles, unless

1 *otherwise required under federal law.*

- 2 (3) Utilization management requirements, including prior authorization and step  
3 therapy, shall not be imposed on any tobacco cessation services provided pursuant  
4 to this section, except in the following circumstances where prior authorization may  
5 be required:
- 6 (a) For a treatment that exceeds the duration recommended by the most recently  
7 published United States Public Health Service clinical practice guidelines on  
8 treating tobacco use and dependence; or
- 9 (b) For services associated with more than two (2) attempts to quit within a  
10 twelve (12) month period.
- 11 (4) Nothing in this section shall be construed to prohibit the Department for Medicaid  
12 Services or a managed care organization contracted to provide Medicaid services  
13 from providing coverage for tobacco cessation services in addition to those  
14 recommended or to deny coverage for services that are not recommended by the  
15 United States Preventive Services Task Force.

16 ➔SECTION 5. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO  
17 READ AS FOLLOWS:

18 *(1) Beginning January 1, 2027, the cabinet shall, in accordance with 42 U.S.C. sec.*  
19 *1396a(e)(14)(L), conduct Medicaid eligibility redeterminations once every six (6)*  
20 *months for individuals who are:*

21 *(a) Described in 42 U.S.C. sec. 1396a(e)(14)(L)(i)(I) and (II); and*

22 *(b) Not exempted under 42 U.S.C. sec. 1396a(e)(14)(L)(ii).*

23 *(2) When conducting eligibility determinations and redeterminations, including but*  
24 *not limited to redeterminations required under subsection (1) of this section, the*  
25 *cabinet shall:*

26 *(a) Access and review information from all available federal and state data*  
27 *systems that may contain information related to eligibility for enrollment or*

1 continued enrollment in the Medicaid program, including but not limited to:

2 1. The Public Assistance Reporting Information System, or PARIS;

3 2. The Transformed Medicaid Statistical Information System, or T-  
4 MSIS;

5 3. The T-MSIS Analytic Files, or TAF; and

6 4. All data described in Section 7 of this Act;

7 (b) Except as provided in subsection (11) of Section 9 of this Act and to the  
8 extent permitted under federal law, issue an initial finding of ineligibility  
9 that may be appealed by the individual through the cabinet's established  
10 appeals process if the cabinet finds or reviews inconsistent or contradictory  
11 data from the various data sources the cabinet is required to review under  
12 paragraph (a) of this subsection and any data source reflects that the  
13 individual whose eligibility is being determined or redetermined is ineligible  
14 to enroll in or continue to be enrolled in the Medicaid program; and

15 (c) Assess and make a determination regarding the individual's eligibility for  
16 Medicaid-covered nonemergency medical transportation services.

17 ➔SECTION 6. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO  
18 READ AS FOLLOWS:

19 For the purpose of identifying and, when appropriate, disenrolling individuals from the  
20 Kentucky Medicaid program who are concurrently enrolled, or suspected of being  
21 concurrently enrolled, in one (1) or more other states' Medicaid programs or are  
22 otherwise ineligible for enrollment in the Kentucky Medicaid program because they no  
23 longer reside in Kentucky, to the extent permitted under federal law:

24 (1) The cabinet shall:

25 (a) On at least a quarterly basis, review the Public Assistance Reporting  
26 Information System, or PARIS, match files submitted to the state by the  
27 federal Administration for Children and Families;

1 (b) Identify individuals enrolled in the Kentucky Medicaid program who may  
2 be concurrently enrolled in one (1) or more other states' Medicaid  
3 programs;

4 (c) Notify any individual suspected of being concurrently enrolled in the  
5 Kentucky Medicaid program and one (1) or more other states' Medicaid  
6 programs within thirty (30) days of identification under paragraph (b) of  
7 this subsection. Notifications made under this paragraph shall inform  
8 individuals:

9 1. That they are required to submit proof of current residency in the  
10 Commonwealth within thirty (30) days;

11 2. Of the process for submitting proof of current residency to the cabinet  
12 and the documents required to be submitted to validate current  
13 residency in the Commonwealth; and

14 3. That failure to submit proof of current residency in the  
15 Commonwealth within thirty (30) days shall result in the individual  
16 being disenrolled from the Medicaid managed care organization in  
17 which the individual is enrolled or assigned;

18 (d) For individuals who fail to respond as required under paragraph (c) of this  
19 subsection:

20 1. Disenroll the individual from the Medicaid managed care  
21 organization in which the individual is enrolled or assigned and place  
22 the individual in the Medicaid fee-for-service program; and

23 2. Make a second attempt to notify the individual within forty-five (45)  
24 days from the date on which the notice required under paragraph (c)  
25 of this subsection was made. Notifications made under this  
26 subparagraph shall inform individuals:

27 a. That they must submit proof of current residency in the

1 Commonwealth within thirty (30) days;

2 b. Of the process for submitting proof of current residency to the  
3 cabinet and the documents required to be submitted to validate  
4 current residency in the Commonwealth; and

5 c. That failure to submit proof of current residency in the  
6 Commonwealth within thirty (30) days shall result in the  
7 individual being disenrolled from the Kentucky Medicaid  
8 program;

9 (e) Not make capitation payments to any managed care organization with  
10 whom the cabinet contracts for the delivery of Medicaid services on behalf  
11 of any individual disenrolled from managed care in accordance with  
12 paragraphs (c) and (d) of this subsection;

13 (f) Upon receipt of a notification required under subsection (2)(b) of this  
14 section, provide notice in accordance with paragraphs (c) and (d) of this  
15 subsection to the individual identified by the managed care organization  
16 and disenroll the individual as required under paragraphs (c) and (d) of this  
17 subsection; and

18 (g) Establish administrative penalties for any managed care organization that  
19 fails to comply with the requirements of subsection (2) of this section;

20 (2) Each managed care organization with whom the cabinet contracts for the  
21 delivery of Medicaid services shall:

22 (a) On at least a monthly basis, make all reasonable efforts to identify any  
23 individual who is:

24 1. Enrolled in the Kentucky Medicaid program;

25 2. Served by, enrolled with, or assigned to the managed care  
26 organization; and

27 3. Covered by, insured by, or enrolled with the managed care

1                   organization, the managed care organization's parent company, or  
 2                   any subsidiary of the managed care organization or its parent  
 3                   company in another state, regardless of the type of coverage provided  
 4                   in the other state;

5                   **(b) Promptly notify the cabinet of any individual identified in accordance with**  
 6                   **paragraph (a) of this subsection; and**

7                   **(c) On a monthly basis, report to the Department for Medicaid Services efforts**  
 8                   **and activities undertaken to comply with paragraph (a) of this subsection;**  
 9                   **and**

10                  **(3) (a) The cabinet shall impose a penalty of one thousand dollars (\$1,000) for**  
 11                  **each violation of:**

12                   **1. Subsection (2)(a) and (c) of this section with each month in which a**  
 13                   **managed care organization fails to comply with subsection (2)(a) and**  
 14                   **(c) of this section constituting a separate violation; and**

15                   **2. Subsection (2)(b) of this section.**

16                  **(b) Penalties collected under this subsection shall be deposited into the**  
 17                  **Medicaid managed care organization compliance fund established in**  
 18                  **Section 11 of this Act.**

19                  ➔ Section 7. KRS 205.178 is amended to read as follows:

20                  (1) **On at least a monthly basis**~~[At a regularly scheduled interval]~~, each enrollment or  
 21                  benefit tracking agency associated with the Medicaid program or the Supplemental  
 22                  Nutrition Assistance Program of the cabinet shall receive and review information  
 23                  from the Kentucky Lottery Corporation **and the Kentucky Horse Racing and**  
 24                  **Gaming Corporation** concerning individuals enrolled ~~[as recipients]~~ in the  
 25                  Medicaid program or the Supplemental Nutrition Assistance Program that **may**  
 26                  **indicate**~~[indicates]~~ a change in circumstances that **would**~~[may]~~ affect eligibility,  
 27                  including but not limited to changes in income or resources.

- 1 (2) On at least a monthly basis, each enrollment or benefit tracking agency associated  
 2 with the Medicaid program or the Supplemental Nutrition Assistance Program of  
 3 the cabinet shall receive and review information from the Vital Statistics Branch  
 4 concerning individuals enrolled in the Medicaid program or the Supplemental  
 5 Nutrition Assistance Program that may indicate~~indicates~~ a change in  
 6 circumstances that would~~may~~ affect eligibility.
- 7 (3) On at least a quarterly basis, each enrollment or benefit tracking agency associated  
 8 with the Medicaid program or the Supplemental Nutrition Assistance Program of  
 9 the cabinet shall receive and review information from the ~~Kentucky~~ Office of  
 10 Unemployment Insurance concerning individuals enrolled in the Medicaid program  
 11 or the Supplemental Nutrition Assistance Program that may indicate~~indicates~~ a  
 12 change in circumstances that would~~may~~ affect eligibility, including but not  
 13 limited to changes in employment or wages.
- 14 (4) On at least a quarterly basis, each enrollment or benefit tracking agency associated  
 15 with the Medicaid program or the Supplemental Nutrition Assistance Program of  
 16 the cabinet shall receive and review information, including information from the  
 17 Kentucky Transitional Assistance Program, concerning individuals enrolled in the  
 18 Medicaid program or the Supplemental Nutrition Assistance Program that may  
 19 indicate~~indicates~~ a change in circumstances that would~~may~~ affect eligibility,  
 20 including but not limited to potential changes in residency as identified by out-of-  
 21 state electronic benefit transfer transactions.
- 22 (5) On at least a quarterly basis, each enrollment and benefit tracking agency  
 23 associated with the Medicaid program shall receive and review information from  
 24 the Kentucky Transportation Cabinet, including vehicle registration information,  
 25 concerning individuals enrolled in the Medicaid program that may indicate a  
 26 change in circumstances that would affect eligibility for Medicaid-covered  
 27 nonemergency medical transportation services.

- 1 (6) On at least an annual basis, each enrollment or benefit tracking agency  
2 associated with the Medicaid program shall receive and review information from  
3 the Department of Revenue concerning individuals enrolled in the Medicaid  
4 program that may indicate a change in circumstances that would affect eligibility  
5 for enrollment in the Medicaid program, including but not limited to changes in  
6 adjusted gross income or family composition.
- 7 (7) On at least a monthly basis, each enrollment or benefit tracking agency  
8 associated with the Medicaid program shall receive and review information from  
9 the Department of Corrections concerning individuals enrolled in the Medicaid  
10 program that may indicate a change in circumstances that would affect eligibility  
11 for enrollment in the Medicaid program.
- 12 (8) At a regularly scheduled interval, each enrollment or benefit tracking agency  
13 associated with the Medicaid program shall receive and review information  
14 related to child support payments received by individuals enrolled in the Medicaid  
15 program that may indicate a change in circumstances that would affect eligibility  
16 for enrollment in the Medicaid program.
- 17 (9) On at least a quarterly basis, each enrollment and benefit tracking agency  
18 associated with the Medicaid program shall review information from the National  
19 Change of Address database, or NCOALink, concerning individuals enrolled in  
20 the Medicaid program that may indicate a change in circumstances that would  
21 affect eligibility for enrollment in the Medicaid program.
- 22 (10) The Department for Medicaid Services shall, as permitted under federal law:  
23 (a) Enter into a data exchange agreement with the Social Security  
24 Administration to receive the full file of death information on at least a  
25 quarterly basis; and  
26 (b) Upon receipt of the full file of death information and any update to the file,  
27 disenroll from the Medicaid program any individual whose death is reported

1 *in the full file of death information.*

2 ~~(11)~~~~(5)~~ Notwithstanding any other provision of law to the contrary:

- 3 (a) *The cabinet and* each enrollment or benefit tracking agency associated with  
 4 the Medicaid program or the Supplemental Nutrition Assistance Program ~~of~~  
 5 ~~the cabinet~~ shall enter into a memorandum of understanding with any  
 6 department, agency, or division for information detailed in this section; and
- 7 (b) Any department, agency, or division for information detailed in this section,  
 8 including but not limited to the Kentucky Lottery Corporation, *the Kentucky*  
 9 *Horse Racing and Gaming Corporation,* the Vital Statistics Branch, the  
 10 Office of Unemployment Insurance, ~~and~~ the Department for Community  
 11 Based Services, *the Kentucky Transportation Cabinet, the Department of*  
 12 *Revenue, and the Department of Corrections,* shall enter into any necessary  
 13 memoranda of understanding with the *cabinet or the* enrollment or benefit  
 14 tracking agency associated with the Medicaid program or the Supplemental  
 15 Nutrition Assistance Program requesting an agreement pursuant to paragraph  
 16 (a) of this subsection.

17 ~~(12)~~~~(6)~~ *The cabinet and* each enrollment or benefit tracking agency associated with  
 18 the Medicaid program or the Supplemental Nutrition Assistance Program ~~of the~~  
 19 ~~cabinet~~ may contract in accordance with KRS Chapter 45A with one (1) or more  
 20 independent vendors to provide additional data or information that may indicate a  
 21 change in circumstances that *would*~~may~~ affect eligibility.

22 ~~(13)~~~~(7)~~ *The cabinet and* each enrollment or benefit tracking agency associated with  
 23 the Medicaid program or the Supplemental Nutrition Assistance Program ~~of the~~  
 24 ~~cabinet~~ shall explore joining any multistate cooperative to identify individuals who  
 25 are also enrolled in public assistance programs outside of this state.

26 ~~(14)~~~~(8)~~ If *the cabinet or* an enrollment or benefit tracking agency associated with the  
 27 Medicaid program or the Supplemental Nutrition Assistance Program ~~of the~~

1 ~~cabinet~~] receives information concerning an individual enrolled in the Medicaid  
 2 program or the Supplemental Nutrition Assistance Program that indicates a change  
 3 in circumstances that ~~would~~[may] affect eligibility, **the cabinet or** the enrollment or  
 4 benefit tracking agency or other appropriate agency shall:

5 **(a) For individuals enrolled in the Supplemental Nutrition Assistance Program,**  
 6 review the individual's case; **and**

7 **(b) For individuals enrolled in the Medicaid program, promptly initiate a full**  
 8 **and complete eligibility redetermination for the individual. Any eligibility**  
 9 **redetermination conducted under this paragraph shall be in addition to**  
 10 **semiannual eligibility redeterminations required under Section 5 of this Act**  
 11 **and 42 U.S.C. sec. 1396a(e)(14)(L)(i).**

12 ~~(15)~~~~(9)~~ (a) Unless expressly required by federal law or as permitted by this  
 13 subsection, the cabinet shall not seek, apply for, accept, or renew any waiver  
 14 of work requirements established by the Supplemental Nutrition Assistance  
 15 Program under 7 U.S.C. sec. 2015(o) without first obtaining specific  
 16 authorization from the General Assembly to do so. The cabinet may, without  
 17 first obtaining specific authorization from the General Assembly, request:

- 18 1. A waiver of Supplemental Nutrition Assistance Program work  
 19 requirements for a county in which the unemployment rate is equal to or  
 20 greater than ten percent (10%);
- 21 2. A waiver of Supplemental Nutrition Assistance Program work  
 22 requirements in a county in which the cabinet determines that other  
 23 economic conditions are severe enough to necessitate a waiver; or
- 24 3. A statewide waiver of Supplemental Nutrition Assistance Program work  
 25 requirements if the state's unemployment rate is equal to or greater than  
 26 ten percent (10%).

27 (b) The cabinet shall not exercise the state's option under 7 U.S.C. sec.

1           2015(o)(6).

2           (c) The cabinet may assign individuals who are subject to work requirements  
3           under 7 U.S.C. sec. 2015(d)(1) to an employment and training program as  
4           defined in 7 U.S.C. sec. 2015(d)(4).

5    ~~(16)~~~~(10)~~ The cabinet shall, in accordance with KRS Chapter 13A, promulgate ~~all rules~~  
6    ~~and~~ administrative regulations necessary for the purposes of carrying out this  
7    section.

8    ~~(17)~~~~(11)~~ Upon request from the Legislative Research Commission, the cabinet ~~for~~  
9    ~~Health and Family Services~~ shall submit a report relating to the number of  
10   individuals discovered utilizing services inappropriately, the number of individuals  
11   who were removed from one (1) or more public assistance programs as a result of a  
12   review under~~pursuant~~ to this section, and the amount of public funds preserved in  
13   total and by public assistance program and aggregated by prior years.

14    ➔ Section 8. KRS 205.5375 is amended to read as follows:

15    (1) As used in this section:

16           (a) "Department" means the Department for Medicaid Services;

17           (b) "Period of presumptive eligibility" has the same meaning as in 42 C.F.R. sec.  
18           435.1101; and

19           (c) "Qualified hospital" has the same meaning as in 42 C.F.R. 435.1110(b).

20    (2) If a qualified hospital determines that an individual meets the criteria for  
21    presumptive eligibility using information provided and attested to by the individual,  
22    the hospital shall:

23           (a) Notify the department of the determination within five (5) business days from  
24           the date of determination in a form prescribed by the department;

25           (b) Provide a written eligibility notice to the individual. The written eligibility  
26           notice shall, at a minimum, include the following information in plain  
27           language and large print:

- 1           1.    The beginning and end dates of the period of presumptive eligibility;
- 2           2.    Notification that the individual is required to make an application for
- 3           Medicaid benefits through the individual's local Department for
- 4           Community Based Services office;
- 5           3.    The location of the individual's local Department for Community Based
- 6           Services office;
- 7           4.    Notification that if the individual does not file a full Medicaid
- 8           application before the last day of the following month, the period of
- 9           presumptive eligibility coverage will end on that day; and
- 10          5.    Notification that if the individual does file a full Medicaid application
- 11          before the last day of the following month, presumptive eligibility
- 12          coverage will continue until an eligibility determination is made on the
- 13          application by the department;
- 14          (c)   Issue a presumptive eligibility identification card or document to the
- 15          presumed eligible individual;
- 16          (d)   Maintain a record of the presumptive eligibility screening for each
- 17          application; and
- 18          (e)   Assist presumptively eligible individuals in completing **and submitting** a full
- 19          Medicaid application **prior to the end of the period of presumptive**
- 20          **eligibility**~~[and understanding any documentation requirements].~~
- 21    (3)   If a qualified hospital determines that an individual does not meet the criteria for
- 22          presumptive eligibility using information provided and attested to by the individual,
- 23          the hospital shall provide the individual with written notification of:
- 24          (a)   The reason for the determination;
- 25          (b)   Notification that the individual may file a full Medicaid application through
- 26          the individual's local Department for Community Based Services office if the
- 27          individual wishes to have a formal determination of eligibility made by the

1 department; and

2 (c) The location of the individual's local Department for Community Based  
3 Services office.

4 (4) Notwithstanding any other provision of law to the contrary and to the extent  
5 permitted under federal law, a pregnant individual shall be limited to one (1) period  
6 of presumptive eligibility per pregnancy.

7 (5) (a) The department shall provide training on all applicable state and federal laws  
8 related to presumptive eligibility to all qualified hospitals.

9 (b) Prior to conducting presumptive eligibility screenings and determinations, a  
10 qualified hospital's staff, contractor, or vendor responsible for presumptive  
11 eligibility screenings and determinations shall be required to complete  
12 presumptive eligibility training provided by the department.

13 (6) If a qualified hospital uses a contractor or other vendor for the purpose of  
14 conducting presumptive eligibility screenings and determinations, the hospital shall  
15 be responsible for monitoring the contractor's or vendor's compliance with all  
16 applicable state and federal laws related to presumptive eligibility.

17 (7) ~~[Within ninety (90) days after July 14, 2022, ]~~The department shall promulgate  
18 administrative regulations in accordance with KRS Chapter 13A that are necessary  
19 to administer this section. Administrative regulations promulgated pursuant to this  
20 subsection shall include but not be limited to a thorough presumptive eligibility  
21 application form to be used by qualified hospitals when making presumptive  
22 eligibility determinations using information provided and attested to by an  
23 individual.

24 → Section 9. KRS 205.200 is amended to read as follows:

25 (1) A needy aged person, a needy blind person, a needy child, a needy permanently and  
26 totally disabled person, or a person with whom a needy child lives shall be eligible  
27 to receive a public assistance grant only if he or she has made a proper application

1 or an application has been made on his or her behalf in the manner and form  
2 prescribed by administrative regulation. No individual shall be eligible to receive  
3 public assistance under more than one (1) category of public assistance for the same  
4 period of time.

5 (2) The secretary shall, by administrative regulations, prescribe the conditions of  
6 eligibility for public assistance in conformity with the public assistance titles of the  
7 Social Security Act, its amendments, and other federal acts and regulations. The  
8 secretary shall also promulgate administrative regulations to allow for between a  
9 forty percent (40%) and a forty-five percent (45%) ratable reduction in the method  
10 of calculating eligibility and benefits for public assistance under Title IV-A of the  
11 Federal Social Security Act. In no instance shall grants to families with no income  
12 be less than the appropriate grant maximum used for public assistance under Title  
13 IV-A of the Federal Social Security Act. As used in this section, "ratable reduction"  
14 means the percentage reduction applied to the deficit between the family's  
15 countable income and the standard of need for the appropriate family size.

16 (3) The secretary may by administrative regulation prescribe as a condition of  
17 eligibility that a needy child regularly attend school, and may further by  
18 administrative regulation prescribe the degree of relationship of the person or  
19 persons in whose home such needy child must reside.

20 (4) The secretary may by administrative regulation prescribe conditions for bringing  
21 paternity proceedings or actions for support in cases of out of wedlock birth or  
22 nonsupport by a parent in the public assistance under Title IV-A of the Federal  
23 Social Security Act program.

24 (5) Public assistance shall not be payable to or in behalf of any individual who has  
25 taken any legal action in his or her own behalf or in the behalf of others with the  
26 intent and purpose of creating eligibility for the assistance.

27 (6) The cabinet shall promptly notify the appropriate law enforcement officials of the

1           furnishing of public assistance under Title IV-A of the Federal Social Security Act  
2           in respect to a child who has been deserted or abandoned by a parent.

3       (7) No person shall be eligible for public assistance payments if, after having been  
4           determined to be potentially responsible, and afforded notice and opportunity for  
5           hearing, he or she refuses without good cause:

6           (a) To register for employment with the state employment service,

7           (b) To accept suitable training, or

8           (c) To accept suitable employment.

9           The secretary may prescribe by administrative regulation, subject to the provisions  
10          of KRS Chapter 13A, standards of suitability for training and employment.

11       (8) To the extent permitted by federal law, scholarships, grants, or other types of  
12          financial assistance for education shall not be considered as income for the purpose  
13          of determining eligibility for public assistance.

14       (9) To the extent permitted by federal law, any money received because of a settlement  
15          or judgment in a lawsuit brought against a manufacturer or distributor of "Agent  
16          Orange" for damages resulting from exposure to "Agent Orange" by a member or  
17          veteran of the Armed Forces of the United States or any dependent of such person  
18          who served in Vietnam shall not be considered as income for the purpose of  
19          determining eligibility or continuing eligibility for public assistance and shall not be  
20          subject to a lien or be available for repayment to the Commonwealth for public  
21          assistance received by the recipient.

22       (10) (a) For the purpose of determining eligibility for medical assistance under Title  
23               XIX of the Social Security Act and compliance with 42 U.S.C. sec.  
24               1396a(xx) and Section 1 of this Act, unless otherwise required by federal law,  
25               the cabinet shall only accept self-attestation of income, residency, age,  
26               household composition, caretaker or relative status, or receipt of other  
27               coverage as verification of last resort prior to enrollment, and the cabinet shall

- 1 not request federal authorization or approval to waive or decline to  
2 periodically check any available income-related data source to verify  
3 eligibility.
- 4 (b) This subsection shall not apply to any individual who is a resident of an  
5 assisted living community as defined in KRS 194A.700 or to a long-term care  
6 facility as defined in KRS 216A.010 or hospital licensed under KRS Chapter  
7 216B that is using self-attestation to determine presumptive eligibility.
- 8 (c) If an individual for medical assistance under Title XIX of the Social Security  
9 Act willingly and knowingly self-attests to falsified information related to  
10 income, residency, age, household composition, caretaker or relative status, or  
11 receipt of other coverage, the cabinet may fine the individual not more than  
12 five hundred dollars (\$500) per offense.
- 13 (11) When determining whether an applicant for services or assistance provided under  
14 this chapter meets the applicable income eligibility guidelines, the cabinet shall use  
15 the most recent income verification data available and consider fluctuating  
16 employment income data.
- 17 (12) If in the normal course of operations, the cabinet finds that an individual has  
18 trafficked, sold, distributed, given, or otherwise transferred an electronic benefit  
19 transfer card issued by the department for money, service, or other valuable  
20 consideration, the cabinet, to the extent permitted under state and federal law:
- 21 (a) Shall through any means practical, including but not limited to garnishment of  
22 future cash assistance benefits, seek recoupment from the individual of any  
23 cash benefits trafficked, sold, distributed, given, or otherwise transferred; and
- 24 (b) May:
- 25 1. Upon the first violation, deem the individual ineligible for all public  
26 assistance programs administered by the cabinet under this chapter for a  
27 period of not more than six (6) months;

- 1           2.    Upon the second violation, deem the individual ineligible for all public  
2           assistance programs administered by the cabinet under this chapter for a  
3           period of not more than twelve (12) months; and
- 4           3.    Upon the third violation, deem the individual ineligible for all public  
5           assistance programs administered by the cabinet under this chapter for a  
6           period of not more than five (5) years.
- 7 (13) (a) Notwithstanding any other provision of Kentucky law, the following shall be  
8           disregarded for the purposes of determining an individual's eligibility for a  
9           means-tested public assistance program, and the amount of assistance or  
10          benefits the individual is eligible to receive under the program:
- 11          1.    Any amount in an ABLE account;
- 12          2.    Any contributions to an ABLE account; and
- 13          3.    Any distribution from an ABLE account for qualified disability  
14          expenses.
- 15          (b) As used in~~For purposes of~~ this subsection:
- 16          1.    "ABLE account" means an account established within any state having a  
17          qualified ABLE program as provided in 26 U.S.C. sec. 529A, as  
18          amended;
- 19          2.    "Kentucky law" includes:
- 20              a.    All provisions of the Kentucky Revised Statutes;
- 21              b.    Any contract to provide Medicaid managed care established  
22              pursuant to this chapter;
- 23              c.    Any agreement to operate a Medicaid program established  
24              pursuant to this chapter; and
- 25              d.    Any administrative regulation promulgated pursuant to this  
26              chapter; and
- 27          3.    "Qualified disability expenses" means expenses described in 26 U.S.C.

1                   sec. 529A of a person who is the beneficiary of an ABLE account.

2 (14) (a) Residency shall not be established for an individual if the individual relocates  
3 to Kentucky with the sole intention of establishing eligibility to receive  
4 medical services, including substance use disorder treatment services under  
5 this chapter.

6 (b) An individual may rebut the sole intention of paragraph (a) of this subsection  
7 by showing proof of residency. Proof of residency shall include but not be  
8 limited to the possession of a valid Kentucky operator's license or a copy of a  
9 deed or property tax bill, utility agreement or bill, or rental housing  
10 agreement.

11           ➔SECTION 10. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO  
12 READ AS FOLLOWS:

13 *Any contract entered into, renewed, or extended on or after the effective date of this*  
14 *Act by the cabinet, or any subdivision thereof, and any managed care organization for*  
15 *the delivery of Medicaid services shall include the following provisions:*

16 *(1) The managed care organization shall be prohibited from:*

17 *(a) Contacting or providing any incentive for Medicaid providers to resubmit*  
18 *claims after an initial submission for the purpose of increasing the*  
19 *managed care organization's risk score;*

20 *(b) Contracting with a vendor or other subcontractor for the purpose of*  
21 *engaging in activities the managed care organization is prohibited from*  
22 *engaging in under paragraph (a) of this subsection;*

23 *(c) Penalizing a primary care provider for the primary care provider's inability*  
24 *to make contact with a Medicaid enrollee that has been assigned to the*  
25 *primary care provider's roster if the primary care provider has made a*  
26 *good-faith effort, as defined by the Department for Medicaid Services in its*  
27 *contract with a managed care organization, to contact the enrollee;*

1 (d) Advertising or otherwise marketing the Medicaid program except to indicate  
2 the managed care organization's participation in the Medicaid program;  
3 and

4 (e) 1. For the purposes of assessing, evaluating, or determining network  
5 adequacy, counting or otherwise including in any analysis of network  
6 adequacy an inactive Medicaid provider.

7 2. As used in this paragraph, "inactive Medicaid provider" means an  
8 enrolled Medicaid provider who has submitted fewer than one (1)  
9 encounter or claim for payment for Medicaid covered services to a  
10 given managed care organization within the pervious twelve (12)  
11 months;

12 (2) The managed care organization shall be required to:

13 (a) Notify the Department for Medicaid Services and the Social Security  
14 Administration in the appropriate county within five (5) business days of  
15 receiving notice from any source of the death of a Medicaid enrollee served  
16 by the managed care organization;

17 (b) Collaborate with the Department for Medicaid Services to implement and  
18 execute a value-based payment model that aligns incentives for enrollees,  
19 providers, managed care organizations, and the Commonwealth to improve  
20 quality and health care outcomes. The value-based payment model required  
21 under this subsection shall include a two percent (2%) withhold from each  
22 managed care organization's capitation amount that can be earned back in  
23 full or in part by the managed care organization through the achievement  
24 of designated value-based measures that shall include but not be limited to:

25 1. Hospital readmission rates;

26 2. Cancer screening rates;

27 3. Child and adolescent well care visits;

1           4. Prenatal and postpartum care;

2           5. Emergency department utilization rates;

3           6. Behavioral health treatment and counseling services; and

4           7. Recovery services; and

5           (c) Comply with:

6           1. This section and Sections 3, 12, 13, and subsection (2) of Section 6 of  
7           this Act;

8           2. All terms, conditions, requirements, performance standards, and  
9           obligations created under or included in the contract between the  
10           managed care organization and the cabinet for the delivery of  
11           Medicaid services;

12           3. KRS 304.17A-708; and

13           4. All sections of Subtitle 17A of KRS Chapter 304 listed in KRS  
14           205.522;

15           (3) (a) If the Department for Medicaid Services receives mail returned as  
16           undeliverable following an attempt to contact a Medicaid beneficiary by  
17           first-class mail, the department shall make a good-faith effort to obtain the  
18           beneficiary's current and correct address. The good-faith effort shall  
19           include:

20           1. First, requesting the beneficiary's current and correct address from  
21           his or her managed care organization;

22           2. Accessing and reviewing all available state and federal data sources,  
23           including but not limited to the National Change of Address database,  
24           from which the department might obtain the beneficiary's current and  
25           correct address; and

26           3. Attempting to obtain the beneficiary's current and correct address  
27           directly from the beneficiary by attempting to contact him or her

1 through at least two (2) of the following means of communication:

2 a. Telephone;

3 b. Text message; and

4 c. Email message.

5 (b) 1. The good-faith effort required under paragraph (a) of this subsection  
 6 shall continue for at least thirty (30) days after the date on which the  
 7 department first requested the beneficiary's current and correct  
 8 address from his or her managed care organization.

9 2. If the department is able to obtain the beneficiary's current and  
 10 correct address, the department shall resend any mail that was  
 11 returned to the department as undeliverable.

12 3. If the department is not able to obtain the beneficiary's current and  
 13 correct address within thirty (30) days after the date on which the  
 14 department first requested the beneficiary's current and correct  
 15 address from his or her managed care organization, the department  
 16 shall, to the extent permitted under federal law, disenroll the  
 17 individual from the Medicaid program pending any appeal that may  
 18 be required or guaranteed under federal law;

19 (4) The Department for Medicaid Services shall, in all instances, exercise its rights  
 20 under a contract with a Medicaid managed care organization to impose all  
 21 remedies available to the department under the terms of the contract, at law, or  
 22 equity if the department determines that the managed care organization or a  
 23 subcontractor acting on behalf of the managed care organization has:

24 (a) Violated any provision of the contract between the department and the  
 25 managed care organization; or

26 (b) Failed to fully comply with any applicable state or federal law or regulation,  
 27 compliance with which is mandated expressly or implicitly by the contract;

1 and

2 (5) (a) Penalties for violations of state and federal law related to the Medicaid  
 3 program, including but not limited to this section, and any other contract  
 4 requirements or prohibitions imposed upon the managed care organization  
 5 by the cabinet, including but not limited to:

6 1. The penalty for a violation of subsection (1)(a) or (b) of this section  
 7 shall be at least five hundred dollars (\$500) for each claim a managed  
 8 care organization requests or incentivizes a provider to resubmit;

9 2. The penalty for a violation of subsection (1)(c) of this section shall be  
 10 at least one thousand dollars (\$1,000) per violation;

11 3. The penalty for a violation of subsection (1)(d) of this section shall be  
 12 at least five thousand dollars (\$5,000) per violation;

13 4. The penalty for a violation of subsection (1)(e) of this section shall be  
 14 at least ten thousand dollars (\$10,000) for each inactive provider  
 15 included in an analysis of network adequacy; and

16 5. The penalty for a violation of subsection (2)(a) of this section shall be  
 17 at least one thousand dollars (\$1,000) per violation.

18 (b) All penalties and fines imposed or assessed against a Medicaid managed  
 19 care organization by the Cabinet for Health and Family Services, including  
 20 but not limited to those penalties established in paragraph (a) of this  
 21 subsection, shall be deposited into the Medicaid managed care organization  
 22 compliance fund established in Section 11 of this Act.

23 ➔SECTION 11. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO  
 24 READ AS FOLLOWS:

25 (1) (a) There is hereby established in the State Treasury a restricted fund to be  
 26 known as the Medicaid managed care organization compliance fund.

27 (b) The fund shall consist of all penalties or fines imposed by the cabinet on a

1 managed care organization for violations of Section 10 of this Act, any  
 2 other contract violation, or any violation of state or federal law related to  
 3 the Medicaid program, regardless of the manner in which the penalty of  
 4 fine is paid by a managed care organization, including but not limited to  
 5 reductions in future capitation payments or any monies withheld by the  
 6 Department for Medicaid Services for payment of penalties or fines.

7 (c) The fund shall be administered by the cabinet.

8 (d) Notwithstanding KRS 45.229, fund amounts not appropriated at the close of  
 9 a fiscal year shall not lapse but shall be carried forward into the next fiscal  
 10 year.

11 (e) Any interest earnings of the fund shall become a part of the fund and shall  
 12 not lapse.

13 (f) Notwithstanding KRS 48.630, expenditures shall not be made from this  
 14 fund unless expressly appropriated by the General Assembly.

15 (g) It is the intent of the General Assembly that monies in the fund shall  
 16 provide financial support for future Medicaid reimbursement rate increases  
 17 upon appropriation by the General Assembly.

18 (2) The cabinet shall submit specific recommendations for the use of monies in the  
 19 Medicaid managed care organization compliance fund to increase certain  
 20 Medicaid reimbursement rates to the Legislative Research Commission for  
 21 referral to the Interim Joint Committees on Appropriations and Revenue and  
 22 Health Services and the Medicaid Oversight and Advisory Board established in  
 23 KRS 7A.273 by November 1, 2027, and November 1 of each following odd-  
 24 numbered year.

25 → Section 12. KRS 205.533 is amended to read as follows:

26 (1) [~~By January 1, 2019,~~] A managed care organization shall maintain[~~establish~~] an  
 27 interactive website[~~Web site~~], operated by the managed care organization, that

1 allows providers to file grievances, appeals, and supporting documentation  
 2 electronically in an encrypted format that complies with federal law and that allows  
 3 a provider to review the current status of a matter relating to an appeal or a  
 4 grievance filed concerning a submitted claim.

5 **(2) Each managed care organization's website established in accordance with**  
 6 **subsection (1) of this section shall include, in a highly visible and easily**  
 7 **accessible manner, the following:**

8 **(a) The name, individual email address, and individual telephone number for**  
 9 **each of the managed care organization's provider relations representatives**  
 10 **for:**

11 **1. Behavioral health;**

12 **2. Physical health; and**

13 **3. Provider contract changes; and**

14 **(b) A detailed explanation, written in plain and simple to understand language,**  
 15 **of the managed care organization's process for:**

16 **1. Internal appeals; and**

17 **2. Providers to request an external, independent third-party review.**

18 **(3) Information required to be accessible on a managed care organization's website**  
 19 **pursuant to subsection (2) of this section shall be kept current and updated within**  
 20 **thirty (30) days of any change to the information.**

21 → Section 13. KRS 205.534 is amended to read as follows:

22 (1) A Medicaid managed care organization **with whom the department contracts for**  
 23 **the delivery of Medicaid services** shall:

24 (a) Provide:

25 1. A toll-free telephone line for providers to contact the insurer for claims  
 26 resolution for forty (40) hours a week during normal business hours in  
 27 this state;

- 1           2. A toll-free telephone line for providers to submit requests for  
2           authorizations of covered services during normal business hours and  
3           extended hours in this state on Monday and Friday through 6 p.m.,  
4           including federal holidays;
- 5           3. With regard to any adverse payment or coverage determination, copies  
6           of all documents, records, and other information relevant to a  
7           determination, including medical necessity criteria and any processes,  
8           strategies, or evidentiary standards relied upon, if requested by the  
9           provider. Documents, records, and other information required to be  
10          provided under this paragraph shall be provided at no cost to the  
11          provider; and
- 12          4. For any adverse payment or coverage determination, a written reply in  
13          sufficient detail to inform the provider of all reasons for the  
14          determination. The written reply shall include information about the  
15          provider's right to request and receive at no cost to the provider  
16          documents, records, and other information under subparagraph 3. of this  
17          paragraph;
- 18          (b) Afford each participating provider the opportunity for an in-person meeting  
19          with a representative of the managed care organization on:
  - 20               1. Any clean claim that remains unpaid in violation of KRS 304.17A-700  
21               to 304.17A-730; and
  - 22               2. Any claim that remains unpaid for forty-five (45) days or more after the  
23               date the claim is received by the managed care organization and that  
24               individually or in the aggregate exceeds two thousand five hundred  
25               dollars (\$2,500);
- 26          (c) Reprocess claims that are incorrectly paid or denied in error, in compliance  
27          with KRS 304.17A-708. The reprocessing shall not require a provider to rebill

1 or resubmit claims to obtain correct payment. ~~A~~~~No~~ claim shall **not** be  
2 denied for timely filing if the initial claim was timely submitted; and

3 (d) Establish processes for internal appeals, including provisions for:

4 1. Allowing a provider to file any grievance or appeal related to the  
5 reduction or denial of the claim within **one hundred twenty (120)**~~sixty~~  
6 ~~(60)~~ days of **confirmed** receipt of a notification from the managed care  
7 organization that payment for a submitted claim has been reduced or  
8 denied;~~and~~

9 2. **a.** Ensuring the timely consideration and disposition of any grievance  
10 or any appeal within thirty (30) days from the date the grievance or  
11 appeal is filed with the managed care organization by a provider  
12 under this paragraph.

13 **b. Failure of the managed care organization to comply with**  
14 **subdivision a. of this subparagraph shall result in a fine or**  
15 **penalty as provided in subsection (6) of this section; and**

16 **3. Ensuring that, following the resolution of an appeal that results in a**  
17 **determination that a monetary amount is owed to a provider, payment**  
18 **is made in full to the provider within thirty (30) days from the date on**  
19 **which the appeal was resolved.**

20 (2) (a) **As used in**~~For the purposes of~~ this subsection:

21 1. "Timely" means that an authorization or preauthorization request shall  
22 be approved:

23 a. For an expedited authorization request, within **twenty-four**  
24 **(24)**~~seventy two (72)~~ hours after receipt of the request. The  
25 timeframe for an expedited authorization request may be extended  
26 by up to fourteen (14) days if:

27 i. The enrollee requests an extension; or

- 1                   ii. The Medicaid managed care organization justifies to the  
2                   department a need for additional information and how the  
3                   extension is in the enrollee's interest; and
- 4                   b. For a standard authorization request, within five (5) calendar~~two~~  
5                   ~~(2) business~~ days. The timeframe for a standard authorization  
6                   request may be extended by up to fourteen (14) additional days if:
- 7                   i. The provider or enrollee requests an extension; or  
8                   ii. The Medicaid managed care organization justifies to the  
9                   department a need for additional information and how the  
10                  extension is in the enrollee's interest; and
- 11                2. a. "Expedited authorization request" means a request for  
12                  authorization or preauthorization where the provider determines  
13                  that following the standard~~—a~~ timeframe could seriously  
14                  jeopardize an enrollee's life or health, or ability to attain, maintain,  
15                  or regain maximum function.~~;~~~~and~~
- 16                  b. A request for authorization or preauthorization for treatment of an  
17                  enrollee with a diagnosis of substance use disorder shall be  
18                  considered an expedited authorization request by the provider and  
19                  the managed care organization.
- 20                (b) A decision by a managed care organization on an authorization or  
21                  preauthorization request for physical, behavioral, or other medically necessary  
22                  services shall be made in a timely and consistent manner so that Medicaid  
23                  members with comparable medical needs receive a comparable, consistent  
24                  level, amount, and duration of services as supported by the member's medical  
25                  condition, records, and previous affirmative coverage decisions.
- 26                (3) (a) Each managed care organization shall report on a monthly basis to the  
27                  department:

- 1           1.    The number and dollar value of claims received that were denied,  
2                    suspended, or approved for payment;
- 3           2.    The number of requests for authorization of services and the number of  
4                    such requests that were approved and denied;
- 5           3.    The number of internal appeals and grievances filed by members and by  
6                    providers and the type of service related to the grievance or appeal, the  
7                    total dollar amount of all denials being appealed, the time of  
8                    resolution, the number of internal appeals and grievances where the  
9                    initial denial was overturned and the type of service and dollar amount  
10                  associated with the overturned denials; ~~and~~
- 11          4.    For each internal appeal or grievance not resolved within sixty (60)  
12                  calendar days, the name of the provider who filed the unresolved  
13                  internal appeal or grievance, the dollar amount of the claim that was  
14                  denied if a denial is being appealed, the reason for the delay in  
15                  resolving the internal appeal or grievance, the current status of the  
16                  internal appeal or grievance, and the outcome determination if  
17                  rendered prior to the filing of the report; and
- 18          5.    Any other information required by the department.
- 19          (b)   The data required in paragraph (a) of this subsection shall be separately  
20                  reported by provider category, as prescribed by the department, and shall at a  
21                  minimum include inpatient acute care hospital services, inpatient psychiatric  
22                  hospital services, outpatient hospital services, residential behavioral health  
23                  services, and outpatient behavioral health services.
- 24          (4)   On a monthly basis, the department shall transmit to the Department of Insurance a  
25                  report of each corrective action plan, fine, or sanction assessed against a Medicaid  
26                  managed care organization for violation of a Medicaid managed care organization's  
27                  contract relating to prompt payment of claims. The Department of Insurance shall

1 then make a determination of whether the contract violation was also a violation of  
2 KRS 304.17A-700 to 304.17A-730.

3 (5) By December 15 of each year, the department shall submit to the Legislative  
4 Research Commission for referral to the Interim Joint Committee on Health  
5 Services, the Legislative Oversight and Investigations Committee, and the  
6 Medicaid Oversight and Advisory Board a report containing the following  
7 information for the previous state fiscal year and reported separately for each  
8 managed care organization with whom the department has contracted for the  
9 delivery of Medicaid services:

10 (a) The number and dollar value of all claims that were received by the  
11 managed care organization and the number and dollar value of those  
12 claims that were approved for payment, denied, or suspended;

13 (b) The number of requests for authorization of services received and the  
14 number of those requests that were approved or denied;

15 (c) The number of internal appeals and grievances filed by Medicaid enrollees  
16 and by providers, the types of services to which the internal appeals and  
17 grievances relate, the total dollar amount of denials that were appealed, the  
18 average length of time to resolution, the number of internal appeals and  
19 grievances where the initial denial was overturned, and the types of services  
20 and dollar amount of overturned denials; and

21 (d) The number of internal appeals and grievances not resolved within sixty  
22 (60) calendar days, the ten (10) most common reasons given for delays, the  
23 total dollar amount when a denial is being appealed, and the number of  
24 final determinations made in favor of a provider.

25 (6) Any Medicaid managed care organization that fails to comply with subsection  
26 (1)(d)2. of this section or KRS 205.522, 205.532 to 205.536, or~~and~~ 304.17A-515  
27 may be subject to fines, penalties, and sanctions, up to and including termination, as

1 established under its Medicaid managed care contract with the department.

2 **(7) The department may promulgate administrative regulations in accordance with**  
 3 **KRS Chapter 13A to implement and enforce this section.**

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

6 **(1) The provision of nonemergency medical transportation services to eligible**  
 7 **Medicaid enrolled beneficiaries in the Commonwealth shall comply with 42**  
 8 **U.S.C. sec. 1396a(a)(87), 42 C.F.R. sec. 431.53, 42 C.F.R. sec. 440.170, any other**  
 9 **relevant federal law or regulation, and this section, except that this section shall**  
 10 **not apply to any nonemergency medical transportation services, including**  
 11 **transportation via stretcher, covered by a Medicaid managed care organization.**

12 **(2) A nonemergency medical transportation service program administered under this**  
 13 **section and relevant federal law shall:**

14 **(a) Be administered under a regional brokerage delivery model;**

15 **(b) 1. Utilize a capitated payment model.**

16 **2. Capitation payments made to regional brokers shall be:**

17 **a. Actuarially sound;**

18 **b. Set by an actuary contracted by the Department for Medicaid**  
 19 **Services;**

20 **c. Calculated based only on the number of nonemergency medical**  
 21 **transportation service eligible Medicaid enrollees, as determined**  
 22 **by the Department for Medicaid Services in accordance with**  
 23 **subsection (2)(c) of Section 5 of this Act, within a given region**  
 24 **and shall not be based on the total number of Medicaid**  
 25 **enrollees; and**

26 **d. Calculated separately for each region with consideration given to**  
 27 **each region's average trip time, average trip distance or average**

1 mileage per trip, and other region-specific factors, including but  
 2 not limited to geography, terrain, and population density; and

3 (c) Require regional brokers to:

4 1. Achieve an annual medical loss ratio for each state fiscal year as  
 5 required under subsection (3) of this section;

6 2. Provide a remittance to the state of any excess capitation payments for  
 7 any state fiscal year in which the regional broker fails to achieve an  
 8 annual medical loss ratio as required under subsection (3) of this  
 9 section;

10 3. a. Ensure that all vehicles used to provide Medicaid-covered  
 11 nonemergency medical transportation services are equipped with  
 12 a global positioning system device that enables the broker to  
 13 determine the precise location of the vehicle at all times when the  
 14 vehicle is being operated to provide nonemergency medical  
 15 transportation services.

16 b. Any cost that may be associated with the requirement to equip  
 17 vehicles used to provide Medicaid-covered nonemergency  
 18 medical transportation services with a global positioning system  
 19 device shall be borne by the regional broker and not the  
 20 Department for Medicaid Services or any other state agency; and

21 4. Collaborate with the Department for Medicaid Services, or another  
 22 agency in state government or a private entity with which the  
 23 department has contracted for the administration of a nonemergency  
 24 medical transportation service program, to implement and execute a  
 25 performance-based payment model that aligns incentives for Medicaid  
 26 enrollees, drivers, regional brokers, and the Commonwealth to  
 27 improve quality, reliability, and cost-effectiveness in the

1                   nonemergency medical transportation service program. The  
 2                   performance-based payment model required under this subparagraph  
 3                   shall include a two percent (2%) withhold from each regional broker's  
 4                   capitation amount that can be earned back in full or in part by the  
 5                   regional transportation broker through achievement of designated  
 6                   performance-based measures which shall:

7                   a. Be developed in a manner that reflects the unique circumstances  
 8                   of each region; and

9                   b. Include but not be limited to:

10                   i. Utilization rates;

11                   ii. The number of nonemergency medical transportation  
 12                   service trips completed;

13                   iii. The number of nonemergency medical transportation  
 14                   service trips canceled or rescheduled;

15                   iv. The number of delayed nonemergency medical  
 16                   transportation service trips;

17                   v. Average trip time;

18                   vi. Average miles per trip;

19                   vii. The amount of time required to schedule a nonemergency  
 20                   medical transportation service; and

21                   viii. Rider satisfaction.

22                   (3) (a) For the state fiscal year beginning July 1, 2026, regional brokers shall be  
 23                   required to achieve a medical loss ratio of at least eighty-five percent (85%).

24                   (b) For the state fiscal year beginning July 1, 2027, regional brokers shall be  
 25                   required to achieve a medical loss ratio of at least eighty-seven percent  
 26                   (87%).

27                   (c) For the state fiscal year beginning July 1, 2028, regional brokers shall be

1           required to achieve a medical loss ratio of at least eighty-nine percent  
2           (89%).

3           (d) For the state fiscal year beginning July 1, 2029, and each state fiscal year  
4           thereafter, regional brokers shall be required to achieve a medical loss ratio  
5           of at least ninety percent (90%).

6           (4) Utilization rates for nonemergency medical transportation services, including  
7           when calculated by an actuary under subsection (2) of this section, shall consider  
8           only nonemergency medical transportation service eligible Medicaid enrollees, as  
9           determined by the Department for Medicaid Services in accordance with  
10           subsection (2)(c) of Section 5 of this Act, within a given region and shall not be  
11           based on the total number of Medicaid enrollees.

12           (5) (a) A skilled nursing facility or hospital shall be permitted to provide  
13           nonemergency medical transportation services for residents of the skilled  
14           nursing facility or patients of the hospital if the transportation service would  
15           be considered a Medicaid-covered service if provided by a driver contracted  
16           by a nonemergency medical transportation service regional broker.

17           (b) A skilled nursing facility or hospital that provides nonemergency medical  
18           transportation services under this subsection shall be eligible for  
19           reimbursement by the locally contracted nonemergency medical  
20           transportation service regional broker at the same mileage rate as would be  
21           paid to a driver contracted by the regional broker for the same service.

22           (c) This subsection shall not establish or impose upon a skilled nursing facility  
23           or hospital any duty or responsibility to provide nonemergency  
24           transportation services to an individual who is not a resident of the facility  
25           or patient of the hospital.

26           (6) When submitting data or reports to the Department for Medicaid Services or any  
27           other agency of state government with responsibility for oversight or

1 administration of the nonemergency medical transportation services, the chief  
 2 executive officer, chief financial officer, president, executive director, or another  
 3 officer of a regional broker shall attest, to the best of his or her knowledge, to the  
 4 truthfulness, accuracy, and completeness of all data or reports at the time of  
 5 submission.

6 (7) Beginning in 2027, the Department for Medicaid Services shall conduct an  
 7 annual review of the nonemergency medical transportation service program and  
 8 submit a report to the Legislative Research Commission for referral to the  
 9 Interim Joint Committees on Health Services and Appropriations and Revenue  
 10 and the Medicaid Oversight and Advisory Board by July 1 of each year. The  
 11 review and report required by this subsection shall, at a minimum, include  
 12 information and recommendations for the following:

13 (a) Utilization rates;

14 (b) The number of nonemergency medical transportation service trips  
 15 completed;

16 (c) The number of nonemergency medical transportation service trips cancelled  
 17 or rescheduled, including the reason for cancellation or rescheduling;

18 (d) The number of delayed nonemergency medical transportation service trips;

19 (e) Average trip time;

20 (f) Average miles per trip;

21 (g) The amount of time required to schedule a nonemergency medical  
 22 transportation service;

23 (h) Rider satisfaction; and

24 (i) The performance-based payment model required under subsection (5) of  
 25 this section.

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

1 (1) As used in this section:

2 (a) "Department":

3 1. Means the Department for Medicaid Services; and

4 2. Includes any other agency of state government or nongovernmental  
 5 entity contracted by the department to administer any aspect of a  
 6 waiver program;

7 (b) "Waiver program" means a 1915(c) home and community-based waiver  
 8 program approved by the federal Centers for Medicare and Medicaid  
 9 Services and administered by the department or any other subdivision of the  
 10 cabinet; and

11 (c) "Waiver program application" means any waiver program application,  
 12 including a waiver waitlist application or application to begin receiving  
 13 waiver program services.

14 (2) (a) The department shall require any individual applying for waiver program  
 15 services, including any individuals applying for or requesting placement on  
 16 a waiver waitlist, to submit a completed waiver program application that  
 17 includes a provider's recommendation for waiver program services and  
 18 provider attestation to the primary diagnosis for which the individual is  
 19 seeking waiver program services.

20 (b) Except as provided in paragraph (c) of this subsection, the department shall  
 21 not place any individual on a waiver waitlist or approve any individual to  
 22 receive waiver program services if the individual has not completed and  
 23 submitted a waiver program application that includes a provider's  
 24 recommendation for waiver program services and provider attestation to the  
 25 primary diagnosis for which the individual is seeking waiver program  
 26 services.

27 (c) An individual who was placed on a waiver waitlist on or before the effective

1 date of this Act shall be allowed twelve (12) months from the effective date  
2 of this Act to submit a waiver program application that includes a provider's  
3 recommendation for waiver program services and provider attestation to the  
4 primary diagnosis for which the individual is seeking waiver program  
5 services. Any individual who was placed on a waiver waitlist on or before  
6 the effective date of this Act who fails to comply with the requirements of  
7 this paragraph shall be removed from the waiver waitlist.

8 (d) As used in this subsection, "provider" means a physician or physician  
9 assistant licensed under KRS Chapter 311, an advanced practice registered  
10 nurse licensed under KRS Chapter 314, or a licensed psychologist licensed  
11 under KRS Chapter 319.

12 (3) By July 1, 2026, the department shall identify, designate, and require the use of a  
13 waiver-specific level of care assessment tool for each waiver program operated by  
14 the department. The level of care assessment tools designated under this  
15 subsection shall:

16 (a) Be nationally recognized;

17 (b) At a minimum, recommend the frequency, duration, and intensity of  
18 services needed by the individual; and

19 (c) Be age-appropriate relative to the population served by the waiver program  
20 for which it is designated.

21 (4) All level of care assessments, including annual level of care reevaluations, shall  
22 utilize the waiver-specific level of care assessment tools designated in accordance  
23 with subsection (3) of this section.

24 (5) Notwithstanding subsections (3) and (4) of this section, an individual who is  
25 eighteen (18) years of age or younger and currently receiving waiver services on  
26 the effective date of this Act shall not be reassessed using the level of care  
27 assessment tools designated under subsection (3) of this section and shall

1 continue to be reassessed as required under state and federal law using the  
 2 assessment tool in effect on the effective date of this Act until he or she reaches  
 3 eighteen (18) years of age.

4 (6) The department shall undertake efforts to encourage waiver service providers to  
 5 develop innovative programs that increase the quality and value of care while  
 6 reducing costs of the waiver programs.

7 (7) (a) Except as provided in paragraphs (b) and (c) of this subsection and to the  
 8 extent permitted under federal law, in order to be eligible for enrollment in  
 9 a waiver program an individual shall be a citizen of the United States or a  
 10 qualified alien as defined in 8 U.S.C. sec. 1641 and have been a resident of  
 11 the Commonwealth for at least one (1) year prior to enrollment.

12 (b) Notwithstanding paragraph (a) of this subsection, an individual who has  
 13 been a resident of the Commonwealth for less than one (1) year may be  
 14 enrolled in a waiver program for which there is no waitlist.

15 (c) This subsection shall not apply to:

16 1. Individuals enrolled in a waiver program prior to the effective date of  
 17 this Act; or

18 2. Members of the United States Armed Forces, their spouses or  
 19 dependents, or veterans.

20 (8) (a) The cabinet shall reserve capacity in each waiver program to ensure  
 21 availability of waiver slots for individuals determined to have an emergency  
 22 need status and shall develop waitlist management policies for individuals  
 23 seeking emergency placement in a waiver program, including but not  
 24 limited to, by January 1, 2027, for each waiver program, development of  
 25 waiver-specific emergency need allocation criteria for any waiver program  
 26 for which such criteria do not already exist on the effective date of this Act.

27 (b) Allocation criteria developed pursuant to this subsection shall prioritize the

1 allocation of reserve capacity waiver slots to individuals determined through  
 2 assessment to be in need of skilled nursing services through a waiver  
 3 program.

4 (9) (a) For the purposes of identifying and eliminating waste, fraud, and abuse in  
 5 the 1915(c) waiver programs, any person who knows or has reasonable  
 6 cause to believe that a violation of waiver program policy or law, including  
 7 but not limited to this section, this chapter, any administrative regulation  
 8 promulgated under this chapter, waiver program documents approved by  
 9 the federal Centers for Medicare and Medicaid Services, federal Medicaid-  
 10 related statutes or regulations, or contracts entered into by any agency of  
 11 state government for administration of the waiver programs, has been or is  
 12 being committed by any person, corporation, or entity, shall report or cause  
 13 to be reported to the Office of Medicaid Fraud and Abuse Control in the  
 14 Office of the Attorney General, or the Medicaid Fraud and Abuse hotline as  
 15 required under KRS 205.8465.

16 (b) This subsection and KRS 205.8465 shall apply to area development districts,  
 17 or any other agency of state government, quasi-governmental agency, or  
 18 private entity tasked with administering or overseeing a patient directed  
 19 services program under which waiver participants are permitted to directly  
 20 employ caregiving staff. Any person who knows or has reasonable cause to  
 21 believe that any fraudulent activity in the hiring, employment, or  
 22 compensation of patient directed services staff has occurred or is ongoing  
 23 shall report or cause to be reported to the Office of Medicaid Fraud and  
 24 Abuse Control.

25 (10) On a quarterly basis beginning July 1, 2026, the cabinet shall prepare and submit  
 26 a report to the Legislative Research Commission for referral to the Interim Joint  
 27 Committees on Appropriations and Revenue and Families and Children and the

1 Medicaid Oversight and Advisory Board on waiver program expenditures and  
 2 waiver service utilization rates for the quarter immediately preceding the most  
 3 recent quarter.

4 ➔SECTION 16. A NEW SECTION OF KRS 7A.270 TO 7A.290 IS CREATED  
 5 TO READ AS FOLLOWS:

6 (1) The General Assembly finds and declares that:

7 (a) The ability to conduct thorough and systematic evaluations of state agencies  
 8 and their various departments, divisions, and programs is necessary to  
 9 ensure that the General Assembly has access to factual information  
 10 necessary to discharge its legislative duties;

11 (b) Chief among the General Assembly's legislative duties is the responsibility  
 12 to engage in meaningful legislative oversight of state agencies and their  
 13 various departments, divisions, and programs, including but not limited to  
 14 the Cabinet for Health and Family Services, the Department for Medicaid  
 15 Services, and the Medicaid program;

16 (c) The General Assembly's legislative duties also include the responsibility to  
 17 engage in effective, data-driven, and evidence-based policy making and the  
 18 appropriation of funds to provide for the effective and efficient  
 19 administration of the Medicaid program in a manner that is transparent,  
 20 responsive to the health care needs of the Commonwealth's most vulnerable  
 21 citizens, and representative of responsible stewardship of taxpayer dollars;

22 (d) The duty to engage in effective, data-driven, and evidence-based policy  
 23 making and the appropriation of funds related to the Medicaid program and  
 24 meaningful legislative oversight is only possible when the General Assembly  
 25 has immediate and unobstructed access to current and timely data,  
 26 evidence, records, and information that may be in the possession of or  
 27 housed within the cabinet and its various departments and divisions;

- 1 (e) Existing policies and procedures for the acquisition of current and timely  
 2 data, evidence, records, and information by the General Assembly from the  
 3 cabinet and its various departments and divisions is unnecessarily  
 4 bureaucratic and burdensome in nature and frequently results in untimely  
 5 delays that hinder the General Assembly's ability to discharge its legislative  
 6 duties; and
- 7 (f) Providing the General Assembly with continuous and ongoing access to  
 8 data, evidence, records, and information pertaining to the Medicaid  
 9 program and the administration thereof is critical to ensuring that the  
 10 General Assembly is able to conduct the thorough and systematic  
 11 evaluations that are a necessary precursor to the body's effective and  
 12 meaningful discharge of its oversight, policy-making, and appropriation  
 13 duties.
- 14 (2) (a) No later than fourteen (14) calendar days after the effective date of this Act,  
 15 the cabinet shall provide the Commission with a comprehensive and  
 16 exhaustive list of all databases, datasets, electronic records, and files  
 17 pertaining to the Medicaid program or any aspect thereof that are  
 18 maintained by or in the possession of the cabinet or any of its various  
 19 departments and divisions.
- 20 (b) No later than thirty (30) calendar days after the effective date of this Act,  
 21 the director of the Commission shall provide the cabinet with a list of  
 22 databases, datasets, electronic records, and files determined by the director  
 23 to be necessary for the meaningful and effective discharge of legislative  
 24 duties, including oversight, policy making, and the appropriation of funds to  
 25 provide for the administration of the Medicaid program by the General  
 26 Assembly.
- 27 (c) No later than July 1, 2026, the cabinet shall provide the General Assembly

1 with continuous and ongoing access to all databases, datasets, electronic  
 2 records, and files determined by the director of the Commission to be  
 3 necessary for the meaningful and effective discharge of legislative duties,  
 4 including oversight, policy making, and the appropriation of funds to  
 5 provide for the administration of the Medicaid program by the General  
 6 Assembly.

7 (3) In providing the continuous and ongoing access required under subsection (2) of  
 8 this section, the cabinet shall:

9 (a) Ensure that the director of the Commission and any nonpartisan employee  
 10 thereof designated by the director have electronic, machine-readable, read-  
 11 only, on-demand access at their regular workstations to all databases,  
 12 datasets, electronic records, and files determined by the director of the  
 13 Commission to be necessary for the meaningful and effective discharge of  
 14 legislative duties by the General Assembly;

15 (b) Consult with the director of the Commission and the Kentucky Office of  
 16 Information Technology on the manner and method by which access is  
 17 provided; and

18 (c) Provide training on methods to access the databases, datasets, electronic  
 19 records, and files in a secure manner to the director of the Commission and  
 20 any nonpartisan employee thereof designated by the director.

21 (4) The Commission and the cabinet may enter into a memorandum of  
 22 understanding governing the Commission's access to the shared databases,  
 23 datasets, electronic records, and files. Any memorandum of understanding that  
 24 may be entered into under this subsection:

25 (a) Shall not preclude or prohibit the Commission from providing information  
 26 shared with the Commission under this section to any vendor or entity with  
 27 which the Commission may contract for the purpose of analyzing,

1 reviewing, studying, investigating, or evaluating the Medicaid program or  
 2 any aspect thereof, including but not limited to any vendor with which the  
 3 Commission may contract pursuant to Section 20 of this Act;

4 (b) May include requirements for otherwise ensuring and maintaining the  
 5 confidentiality and security of all databases, datasets, electronic records,  
 6 and files shared with the Commission under this section, including but not  
 7 limited to requirements that may be necessary to comply with the Health  
 8 Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191;  
 9 and

10 (c) Shall be no more restrictive than any other current memorandum of  
 11 understanding between the cabinet and any other entity governing access to  
 12 data shared with the Commission under this section.

13 (5) The list of databases, datasets, electronic records, and files submitted by the  
 14 director of the Commission pursuant to subsection (2)(b) of this section may be  
 15 amended by the director of the Commission as the needs of the General Assembly  
 16 change. When the cabinet is notified of such an amendment, the cabinet shall  
 17 ensure that the Commission is provided with access to any newly requested  
 18 databases, datasets, electronic records, or files within thirty (30) calendar days.

19 (6) (a) In addition to the data-sharing requirements established in subsections (2),  
 20 (3), (4), and (5) of this section, the cabinet shall provide the Commission  
 21 with a copy of:

22 1. Any external audit report related to the Medicaid program prepared by  
 23 any external federal or state entity, including but not limited to the  
 24 federal Centers for Medicare and Medicaid Services, the United States  
 25 Department of Health and Human Services Office of the Inspector  
 26 General, or the Auditor of Public Accounts;

27 2. Any report required under 42 C.F.R. sec. 433, or 42 C.F.R. sec. 438

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Subpart B or E;

- 3. Any report or data that may be submitted to the cabinet by any vendor or entity with which the cabinet has contracted for administration, examination, study, or review of any aspect of the Medicaid program, including but not limited to:
  - a. Medicaid managed care capitation rate certifications;
  - b. Nonemergency medical transportation rate certifications; and
  - c. Any medical loss ratio reports that require approval by the federal Centers for Medicare and Medicaid Services; and
- 4. Any other report or action that requires approval by the federal Centers for Medicare and Medicaid Services.

(b) All reports required to be provided to the Commission under this subsection shall be provided within thirty (30) calendar days of the date on which the report is completed or delivered to the cabinet.

➔SECTION 17. A NEW SECTION OF KRS 7A.270 TO 7A.290 IS CREATED TO READ AS FOLLOWS:

(1) In order to facilitate the board's ongoing efforts to continuously improve health outcomes in a cost-efficient and effective manner, the Commission shall collaborate with the University of Kentucky and the University of Louisville to design and develop a web-based healthcare transparency dashboard that tracks, at a minimum:

- (a) Leading health indicators;
- (b) Performance indicators for Medicaid managed care organizations;
- (c) Performance indicators for Medicaid-participating providers; and
- (d) Performance indicators for the department.

(2) Performance indicators for Medicaid managed care organizations shall include but not be limited to:

1 (a) Follow-up after emergency department visits;

2 (b) Cancer screenings;

3 (c) Child and adolescent well-care visits;

4 (d) Postpartum care;

5 (e) Diabetes care and management; and

6 (f) Hypertension care and management.

7 (3) The healthcare transparency dashboard shall be:

8 (a) Overseen by a subcommittee of the board established in accordance  
 9 subsection (4) of Section 19 of this Act; and

10 (b) Maintained and operated by the Commission.

11 → Section 18. KRS 7A.283 is amended to read as follows:

12 The board, consistent with its purpose as established in KRS 7A.273, shall have the  
 13 authority to:

14 (1) Require any of the following entities to provide any and all information necessary  
 15 to carry out the board's duties, including any contracts entered into by the  
 16 department, the cabinet, or any other state agency related to the administration of  
 17 any aspect of the Medicaid program or the delivery of Medicaid benefits or  
 18 services:

19 (a) The cabinet;

20 (b) The department;

21 (c) Any other state agency;

22 (d) Any Medicaid managed care organization with whom the department has  
 23 contracted for the delivery of Medicaid services;

24 (e) The state pharmacy benefit manager contracted by the department pursuant to  
 25 KRS 205.5512; and

26 (f) Any other entity contracted by a state agency to administer or assist in  
 27 administering any aspect of the Medicaid program or the delivery of Medicaid

- 1 benefits or services;
- 2 (2) Establish a uniform format for reports and data submitted to the board and the  
3 frequency, which may be monthly, quarterly, semiannually, annually, or biannually,  
4 and the due date for the reports and data;
- 5 (3) Conduct public hearings in furtherance of its general duties, at which it may request  
6 the appearance of officials of any state agency and solicit the testimony of  
7 interested groups and the general public;
- 8 (4) Establish any advisory committees or subcommittees of the board that the board  
9 deems necessary to carry out its duties **and upon approval of the Commission:**  
10 **(a) Include in the membership of an advisory committee or subcommittee**  
11 **individuals who are not members of the board; and**  
12 **(b) Appoint as co-chairs of an advisory committee or subcommittee individuals**  
13 **who are not members of the General Assembly;**
- 14 (5) Recommend that the Auditor of Public Accounts perform a financial or special  
15 audit of the Medicaid program or any aspect thereof; and
- 16 (6) Subject to selection and approval by the [~~Legislative Research~~]Commission, utilize  
17 the services of consultants, analysts, actuaries, legal counsel, and auditors to render  
18 professional, managerial, and technical assistance, as needed.

19 → Section 19. KRS 7A.286 is amended to read as follows:

- 20 (1) The board, consistent with its purpose as established in KRS 7A.273, shall:
- 21 (a) On an ongoing basis, conduct an impartial review of all state laws and  
22 regulations governing the Medicaid program and recommend to the General  
23 Assembly any changes it finds desirable with respect to program  
24 administration, including delivery system models, program financing, benefits  
25 and coverage policies, reimbursement rates, payment methodologies, provider  
26 participation, or any other aspect of the program;
- 27 (b) On an ongoing basis, review any change or proposed change in federal laws

1 and regulations governing the Medicaid program and report to the Legislative  
 2 Research Commission on the probable costs, possible budgetary implications,  
 3 potential effect on healthcare outcomes, and the overall desirability of any  
 4 change or proposed change in federal laws or regulations governing the  
 5 Medicaid program;

6 (c) At the request of the Speaker of the House of Representatives or the President  
 7 of the Senate, evaluate proposed changes to state laws affecting the Medicaid  
 8 program and report to the Speaker or the President on the probable costs,  
 9 possible budgetary implications, potential effect on healthcare outcomes, and  
 10 overall desirability as a matter of public policy;

11 (d) At the request of the ~~[Legislative Research]~~Commission, research issues  
 12 related to the Medicaid program;

13 (e) Beginning in ~~2027~~[2026] and at least once every five (5) years thereafter,  
 14 cause:

15 1. A review to be made of the administrative expenses and operational cost  
 16 of the Medicaid program. The review shall include but not be limited to  
 17 evaluating the level and growth of administrative costs, the potential for  
 18 legislative changes to reduce administrative costs, and administrative  
 19 changes the department may make to reduce administrative costs or  
 20 staffing needs. At the discretion of the ~~[Legislative Research]~~  
 21 ~~]Commission~~, the review may be conducted by a consultant retained by  
 22 the board;

23 ***2. A program evaluation to be conducted of the Medicaid program. In***  
 24 ***any instance in which a program evaluation indicates inadequate***  
 25 ***operating or administrative system controls or procedures,***  
 26 ***inaccuracies, inefficiencies, waste, extravagance, unauthorized or***  
 27 ***unintended activities, or other deficiencies, the board shall report its***

1 findings to the Commission. The program evaluation shall be  
 2 performed by a consultant retained by the board; and

3 3. An actuarial analysis to be performed of the Medicaid program, to  
 4 evaluate the sufficiency and appropriateness of Medicaid  
 5 reimbursement rates established by the department and those paid by  
 6 any managed care organization contracted by the department for the  
 7 delivery of Medicaid services. The actuarial analysis shall be  
 8 performed by an actuary retained by the board;

9 (f) ~~[Beginning in 2027 and at least once every five (5) years thereafter, cause a~~  
 10 ~~program evaluation to be conducted of the Medicaid program. In any instance~~  
 11 ~~in which a program evaluation indicates inadequate operating or~~  
 12 ~~administrative system controls or procedures, inaccuracies, inefficiencies,~~  
 13 ~~waste, extravagance, unauthorized or unintended activities, or other~~  
 14 ~~deficiencies, the board shall report its findings to the Legislative Research~~  
 15 ~~Commission. The program evaluation shall be performed by a consultant~~  
 16 ~~retained by the board;~~

17 (g) ~~Beginning in 2028 and at least once every five (5) years thereafter, cause an~~  
 18 ~~actuarial analysis to be performed of the Medicaid program, to evaluate the~~  
 19 ~~sufficiency and appropriateness of Medicaid reimbursement rates established~~  
 20 ~~by the department and those paid by any managed care organization~~  
 21 ~~contracted by the department for the delivery of Medicaid services. The~~  
 22 ~~actuarial analysis shall be performed by an actuary retained by the board;~~

23 (h) ~~]Beginning in 2029 and at least once every five (5) years thereafter, cause the~~  
 24 ~~overall health of the Medicaid population to be assessed. The assessment shall~~  
 25 ~~include but not be limited to a review of health outcomes, healthcare~~  
 26 ~~disparities among program beneficiaries and as compared to the general~~  
 27 ~~population, and the effect of the overall health of the Medicaid population on~~

1 program expenses. The assessment shall be performed by a consultant  
2 retained by the board; and

3 ~~(g)(i)~~ Beginning in 2026 and annually thereafter, publish a report covering the  
4 board's evaluations and recommendations with respect to the Medicaid  
5 program. The report shall be submitted to the ~~Legislative Research~~  
6 ~~Commission~~ no later than December 1 of each year, and shall include at a  
7 minimum a summary of the board's current evaluation of the program and any  
8 legislative recommendations made by the board.

9 (2) The board, consistent with its purpose as established in KRS 7A.273, may:

10 (a) Review all new or amended administrative regulations related to the Medicaid  
11 program and provide comments to the Administrative Regulation Review  
12 Subcommittee established in KRS 13A.020;

13 (b) Make recommendations to the General Assembly, the Governor, the secretary  
14 of the cabinet, and the commissioner of the department regarding program  
15 administration, including benefits and coverage policies, access to services  
16 and provider network adequacy, healthcare outcomes and disparities,  
17 reimbursement rates, payment methodologies, delivery system models,  
18 funding, and administrative regulations. Recommendations made pursuant to  
19 this section shall be nonbinding and shall not have the force of law; and

20 (c) On or before December 1 of each calendar year, adopt an annual research  
21 agenda. The annual research agenda may include studies, research, and  
22 investigations considered by the board to be significant. Board staff shall  
23 prepare a list of study and research topics related to the Medicaid program for  
24 consideration by the board in the adoption of the annual research agenda. An  
25 annual research agenda adopted by the board may be amended by the  
26 ~~Legislative Research~~ Commission to include any studies or reports  
27 mandated by the General Assembly during the next succeeding regular

1 session.

- 2 (3) At the discretion of the ~~[Legislative Research]~~ Commission, studies and research  
3 projects included in an annual research agenda adopted by the board pursuant to  
4 subsection (2)(c) of this section may be conducted by outside consultants, analysts,  
5 or researchers to ensure the timely completion of the research agenda.

6 → Section 20. KRS 205.5372 is amended to read as follows:

- 7 (1) Notwithstanding any provision of law to the contrary, including but not limited to  
8 KRS 205.460 and 205.520, the cabinet shall not:~~[,]~~

9 **(a)** Unless required by federal law, exercise the state's option to develop a basic  
10 health program as permitted under 42 U.S.C. sec. 18051;~~[or]~~

11 **(b)** Make any change *related* to eligibility, coverage, or benefits in the Medicaid  
12 program, including by pursuing or applying for a waiver of federal Medicaid  
13 law under Title 42 of the United States Code, seeking to amend or renew an  
14 existing waiver granted under Title 42 of the United States Code, or pursuing  
15 a state plan amendment, without first obtaining specific authorization from the  
16 General Assembly to do so; **or**

17 **(c)** **Provide any Medicaid benefit or expend general fund moneys on any**  
18 **Medicaid benefit not expressly authorized by the General Assembly or**  
19 **required under federal law.**

- 20 (2) If the cabinet seeks authorization from the General Assembly to establish a basic  
21 health program, apply for a waiver under Title 42 of the United States Code, amend  
22 an existing waiver granted under Title 42 of the United States Code, submit a state  
23 plan amendment, or make any other change to eligibility, coverage, or benefits in  
24 the Medicaid program, the cabinet shall submit a detailed assessment of the  
25 potential fiscal impact of the change for which it is seeking authorization to the  
26 Legislative Research Commission for referral to the Medicaid Oversight and  
27 Advisory Board, the Interim Joint Committee on Appropriations and Revenue, the

1 Interim Joint Committee on Families and Children, the Interim Joint Committee on  
 2 Health Services, and the Office of Budget Review. The fiscal impact assessment  
 3 required by this subsection shall include a review of any anticipated expenditures  
 4 related to the change and any projected savings that may be generated by the  
 5 change for at least two (2) consecutive state fiscal years.

6 (3) If the cabinet seeks authorization from the General Assembly to renew an existing  
 7 waiver granted under Title 42 of the United States Code, the cabinet shall be  
 8 required to submit a fiscal impact assessment as described in subsection (2) of this  
 9 section and an assessment of the efficacy and necessity of the existing waiver. The  
 10 assessments required by this subsection shall be submitted to the Legislative  
 11 Research Commission for referral to the Interim Joint Committee on Appropriations  
 12 and Revenue, the Interim Joint Committee on Families and Children, the Interim  
 13 Joint Committee on Health Services, and the Office of Budget Review at least  
 14 twelve (12) calendar months prior to the date on which the existing waiver is set to  
 15 expire.

16 (4) (a) This section shall not be interpreted as limiting the General Assembly's ability  
 17 to direct the cabinet to make changes to the Medicaid program, including but  
 18 not limited to changes to existing waivers, eligibility, coverage, or benefits.

19 (b) Any act of the General Assembly directing the Cabinet for Health and Family  
 20 Services or the Department for Medicaid Services to make a change to the  
 21 Medicaid program shall constitute authorization for that change as required by  
 22 subsection (1) of this section.

23 (5) (a) This section shall not be interpreted as limiting the cabinet's ability to make  
 24 changes to the Medicaid program that it determines are necessary:

- 25 1. To comply with any requirements that may be imposed by federal law or
- 26 by the federal Centers for Medicare and Medicaid Services;
- 27 2. In response to a national emergency declaration issued by the President

1 of the United States;

2 3. In response to a federal disaster declaration issued by the President of  
3 the United States; or

4 4. In response to a state of emergency declared by the Governor of the  
5 Commonwealth.

6 (b) If the cabinet determines that a change to the Medicaid program is necessary  
7 to comply with requirements imposed by federal law, the cabinet shall, at least  
8 ninety (90) days prior to implementing the necessary changes, submit an  
9 assessment of the potential fiscal impact, as described in subsection (2) of this  
10 section, of those changes to the Legislative Research Commission for referral  
11 to the Medicaid Oversight and Advisory Board, the Interim Joint Committee  
12 on Appropriations and Revenue, the Interim Joint Committee on Families and  
13 Children, the Interim Joint Committee on Health Services, and the Office of  
14 Budget Review.

15 (c) If the cabinet determines that a change to the Medicaid program is necessary  
16 to respond to a national emergency declaration or federal disaster declaration  
17 issued by the President of the United States or a state of emergency declared  
18 by the Governor of the Commonwealth, any such change shall be temporary  
19 in nature and shall only be in effect for the duration of the emergency or  
20 disaster declaration.

21 (6) Subsection (1) of this section shall not apply to:

22 (a) **Reimbursement rates or the fee-for-service fee schedules;**

23 **(b)** Medicaid directed or supplemental payment programs initially approved by  
24 the federal Centers for Medicare and Medicaid Services prior to March 27,  
25 2025, including but not limited to:

26 1. Those payment programs established in KRS 205.5601 to 205.5603,  
27 205.6405 to 205.6408, 205.6411, and 205.6412, and 907 KAR 10:015

1 and 907 KAR 10:830; and

2 2. Any other payment program for a university hospital as defined in KRS  
3 205.639; or

4 ~~(c)~~~~(b)~~ The Medicaid preferred drug list established by the Department for  
5 Medicaid Services as required under KRS 205.5514.

6 (7) As used in this section, the term "Medicaid program" includes the Kentucky  
7 Medical Assistance Program established in KRS 205.510 to 205.5630 and the  
8 Kentucky Children's Health Insurance Program established in KRS 205.6483.

9 ➔SECTION 21. A NEW SECTION OF KRS CHAPTER 13A IS CREATED TO  
10 READ AS FOLLOWS:

11 **When the Cabinet for Health and Family Services, including any department or**  
12 **division thereof, promulgates an administrative regulation related to the Medicaid**  
13 **program that is expressly required by, or is in response to, an act of the General**  
14 **Assembly, the promulgating agency shall:**

15 **(1) At least thirty (30) days before filing the administrative regulation with the**  
16 **regulations compiler, first submit the draft administrative regulation, a detailed**  
17 **implementation plan, and other documents required to be filed by this chapter to**  
18 **the Medicaid Oversight and Advisory Board established in KRS 7A.273 for review**  
19 **and comment; and**

20 **(2) Consider any comments or recommendations provided by the Medicaid Oversight**  
21 **and Advisory Board before filing the administrative regulation.**

22 ➔SECTION 22. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO  
23 READ AS FOLLOWS:

24 **(1) Notwithstanding any provision of law to the contrary, the Department for**  
25 **Medicaid Services shall:**

26 **(a) Extend all contracts with Medicaid managed care organizations in effect on**  
27 **the effective date of this Act through December 31, 2028; and**

1       **(b) Not initiate a procurement process under KRS Chapter 45A for the delivery**  
 2               **of Medicaid Services by one (1) or more managed care organizations prior**  
 3               **to January 1, 2028.**

4       **(2) This section shall expire and have no force or effect after March 15, 2029, unless**  
 5               **extended by an act of the General Assembly.**

6       ➔SECTION 23. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO  
 7 READ AS FOLLOWS:

8       **Notwithstanding any provision of law to the contrary, the Kentucky Medicaid program,**  
 9       **including the Department for Medicaid Services and any managed care organization**  
 10       **with which the department contracts for the delivery of Medicaid services, shall not**  
 11       **provide coverage for prescription drugs when prescribed primarily for weight loss.**

12       ➔SECTION 24. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO  
 13 READ AS FOLLOWS:

14       **(1) The General Assembly finds and declares that:**

15       **(a) Effective management of Medicaid-covered dental services is essential for**  
 16               **the overall health of Medicaid beneficiaries and that specialized**  
 17               **administration of dental services may improve programmatic efficiency,**  
 18               **oral health, and overall health outcomes in the Commonwealth; and**

19       **(b) It is the intent of the General Assembly to authorize the Department for**  
 20               **Medicaid Services to administer Medicaid-covered dental services under an**  
 21               **administrative services organization delivery model beginning January 1,**  
 22               **2029, and for the administrative service organization contracted in**  
 23               **accordance with this section to perform administrative functions necessary**  
 24               **to manage or process claims, prior authorization requests, coordination of**  
 25               **care, network adequacy, and customer service related to Medicaid-covered**  
 26               **dental services.**

27       **(2) As used in this section:**

1 (a) "Administrative service organization" or "ASO" means the entity  
 2 contracted by the department in accordance with subsection (3) of this  
 3 section to perform specified administrative functions related to the  
 4 administration of Medicaid-covered dental services without assuming a  
 5 financial or insurance risk; and

6 (b) "Department" means the Department for Medicaid Services.

7 (3) The department shall:

8 (a) Beginning July 1, 2028, employ a full-time Medicaid dental director who  
 9 shall:

10 1. Be licensed under KRS Chapter 313;

11 2. Report to the commissioner of the department; and

12 3. Be responsible for overseeing the administration of Medicaid-covered  
 13 dental services;

14 (b) Consider any recommendations that may be made by the Medicaid  
 15 Oversight and Advisory Board, or a subcommittee thereof, regarding the  
 16 transition of Medicaid-covered dental services from a managed care  
 17 delivery model to an ASO delivery model;

18 (c) In accordance with KRS Chapter 45A and subsection (5) of this section,  
 19 select and contract with a third-party ASO to administer Medicaid-covered  
 20 dental services. The contract entered into under this paragraph shall have  
 21 an effective date of January 1, 2029;

22 (d) Promulgate administrative regulations in accordance with KRS Chapter  
 23 13A to implement this section;

24 (e) Beginning January 1, 2029:

25 1. Transition all Medicaid beneficiaries from Medicaid managed care  
 26 organization coverage into ASO coverage for the administration of all  
 27 Medicaid-covered dental services; and

- 1            **2. Establish a Dental Services Advisory Panel which shall:**
- 2            **a. Include the following members:**
- 3                    **i. The Medicaid dental director employed pursuant to**
- 4                                    **paragraph (a) of this subsection;**
- 5                    **ii. The members of Technical Advisory Committee on Dental**
- 6                                    **Care established in KRS 205.590; and**
- 7                    **iii. A representative from the ASO contracted with pursuant to**
- 8                                    **paragraph (c) of this subsection;**
- 9            **b. Be attached to the department for administrative purposes; and**
- 10           **c. Provide ongoing consultation, recommendations, and guidance**
- 11                                    **to the department to continually improve administration and**
- 12                                    **delivery of Medicaid-covered dental services; and**
- 13           **(f) On January 1, 2029, begin utilizing an ASO delivery model for the**
- 14                                    **administration of all Medicaid-covered dental services.**
- 15           **(4) (a) The ASO contracted with pursuant to this section shall operate on an**
- 16                                    **administrative-services-only basis. The ASO shall not assume any financial**
- 17                                    **or insurance risk for the cost of dental claims incurred by the**
- 18                                    **Commonwealth, and the Commonwealth shall remain fully financially**
- 19                                    **responsible for all Medicaid-covered dental claims.**
- 20           **(b) The duties and responsibilities of the ASO contracted with pursuant to this**
- 21                                    **section shall be limited to the following administrative services:**
- 22                    **1. Assisting with and facilitating the transitioning of all Medicaid**
- 23                                    **beneficiaries from Medicaid managed care organization coverage into**
- 24                                    **ASO coverage for dental services;**
- 25                    **2. Processing and paying Medicaid-covered dental services claims in**
- 26                                    **accordance with the department's established fee schedule and clinical**
- 27                                    **guidelines;**

- 1            3. Employing utilization control strategies established by the department  
2            and managing all prior authorization requests for Medicaid-covered  
3            dental services;
- 4            4. Providing coordination of care with a Medicaid beneficiary's  
5            Medicaid managed care organization;
- 6            5. Providing customer service and support to Medicaid beneficiaries and  
7            Medicaid-participating dental providers; and
- 8            6. Any other administrative duties or responsibilities contractually  
9            assigned to the ASO by the department.
- 10          (c) The ASO contracted with pursuant to this section shall not include in any  
11          analysis of network adequacy an inactive Medicaid provider as defined in  
12          Section 10 of this Act;
- 13          (5) (a) Notwithstanding any provision of law to the contrary including subsection  
14          (3)(c) of this section, the department shall not initiate a procurement  
15          process to contract with a third-party ASO to administer Medicaid-covered  
16          dental services prior to January 1, 2028.
- 17          (b) Any contract entered into under this section shall be submitted to the  
18          Government Contract Review Committee of the Legislative Research  
19          Commission for comment and review.
- 20          (6) On an annual basis, the department, in collaboration with the Dental Services  
21          Advisory Panel, shall:
- 22          (a) Evaluate the dental ASO's performance based on metrics, including but not  
23          limited to the following:
- 24                  1. Accuracy and timeliness of claims processing;  
25                  2. Efficiency of processing prior authorization requests;  
26                  3. Observed network adequacy improvements;  
27                  4. Availability of and access to services; and

1                    **5. Satisfaction ratings from participating dental service providers and**  
 2                    **Medicaid beneficiaries; and**

3                    **(b) Prepare and submit a report on the evaluation required under this**  
 4                    **subsection to the Legislative Research Commission for referral to the**  
 5                    **Interim Joint Committees on Appropriations and Revenue and Health**  
 6                    **Services, and the Medicaid Oversight and Advisory Board by August 1,**  
 7                    **2029, and August 1 of each year thereafter.**

8                    ➔Section 25. The following KRS sections are repealed:

9                    205.515 Medicaid program delivery system.

10                  311A.172 Provision of nonemergency medical transportation services to a resident by a  
 11                  skilled nursing facility or hospital -- Conditions.

12                  ➔Section 26. If the Cabinet for Health and Family Services or the Department for  
 13                  Medicaid Services determines that a state plan amendment, waiver, or any other form of  
 14                  authorization or approval from any federal agency to implement Sections 1, 2, 3, 4, 5, 6,  
 15                  7, 8, 9, 10, 11, 13, 14, or 15 of this Act is necessary to prevent the loss of federal funds or  
 16                  to comply with federal law, the cabinet or department:

17                  (1) Shall, within 90 days after the effective date of this section, request the  
 18                  necessary federal authorization or approval to implement Sections 1, 2, 3, 4, 5, 6, 7, 8, 9,  
 19                  10, 11, 13, 14, and 15 of this Act; and

20                  (2) May only delay implementation of the provisions of Sections 1, 2, 3, 4, 5, 6,  
 21                  7, 8, 9, 10, 11, 13, 14, and 15 of this Act for which federal authorization or approval was  
 22                  deemed necessary until the federal authorization or approval is granted.

23                  ➔Section 27. Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, and 26 of this Act  
 24                  shall constitute the specific authorization required under KRS 205.5372(1).

25                  ➔Section 28. The Medicaid Oversight and Advisory Board, established in KRS  
 26                  7A.273, is hereby directed to evaluate the Medicaid nonemergency medical  
 27                  transportation, or NEMT, program during the 2026 Legislative Interim. As part of the

1 evaluation directed by this section the board shall:

2 (1) Review all current state and federal laws and regulations related to the  
3 provision of Medicaid-covered NEMT services;

4 (2) Review the current administrative structure of the NEMT program, including  
5 but not limited to:

6 (a) All contracts or memoranda of understanding between the Cabinet for Health  
7 and Family Services and third-party vendors or other state agencies for administration of  
8 the program;

9 (b) The regional broker system; and

10 (c) The use of capitation payments to finance service delivery;

11 (3) Explore alternative administration and delivery models for NEMT services,  
12 including administration and delivery models utilized by other states, to identify best  
13 practices in the administration and delivery of NEMT services;

14 (4) Assess implementation of Section 14 of this Act;

15 (5) Identify strategies to:

16 (a) Reduce the overall cost of the NEMT program;

17 (b) Improve transportation service accessibility, availability, and reliability;

18 (c) Improve customer satisfaction; and

19 (d) Enhance administrative efficiencies; and

20 (6) Submit a report of the board's findings and recommendations related to the  
21 Medicaid NEMT program to the Legislative Research Commission not later than  
22 December 31, 2026.

23 ➔Section 29. Provisions of Section 28 of this Act to the contrary notwithstanding,  
24 the Legislative Research Commission shall have the authority to alternatively assign the  
25 issues identified therein to an interim joint committee or subcommittee thereof, and to  
26 designate a study completion date.

27 ➔Section 30. Sections 28 and 29 of this Act shall have the same legal status as a

1 House Concurrent Resolution.

2       ➔Section 31. Whereas recently enacted federal changes to the Medicaid program  
3 and significant increases in the Commonwealth's Medicaid budget over the last decade  
4 create an urgent need to bolster legislative oversight of the Medicaid program, take  
5 immediate steps to comply with new federal requirements, and ensure that Medicaid  
6 expenditures support the healthcare needs of only those individuals the program is  
7 intended to serve, an emergency is declared to exist, and this Act takes effect upon its  
8 passage and approval by the Governor or upon its otherwise becoming a law.