

205.5356 Contracts for Medicaid services by managed care organizations -- Required terms and provisions -- Prohibited actions -- Requirements -- Disenrollment of beneficiary with unknown address -- Penalties.

Any contract entered into, renewed, or extended on or after April 14, 2026, by the cabinet, or any subdivision thereof, and any managed care organization for the delivery of Medicaid services shall include the following provisions:

- (1) The managed care organization shall be prohibited from:
 - (a) Contacting or providing any incentive for Medicaid providers to resubmit claims after an initial submission for the purpose of increasing the managed care organization's risk score;
 - (b) Contracting with a vendor or other subcontractor for the purpose of engaging in activities the managed care organization is prohibited from engaging in under paragraph (a) of this subsection;
 - (c) Penalizing a primary care provider for the primary care provider's inability to make contact with a Medicaid enrollee that has been assigned to the primary care provider's roster if the primary care provider has made a good-faith effort, as defined by the Department for Medicaid Services in its contract with a managed care organization, to contact the enrollee;
 - (d) Advertising or otherwise marketing the Medicaid program except to indicate the managed care organization's participation in the Medicaid program; and
 - (e)
 1. For the purposes of assessing, evaluating, or determining network adequacy, counting or otherwise including in any analysis of network adequacy an inactive Medicaid provider.
 2. As used in this paragraph, "inactive Medicaid provider" means an enrolled Medicaid provider who has submitted fewer than one (1) encounter or claim for payment for Medicaid covered services to a given managed care organization within the previous twelve (12) months;
- (2) The managed care organization shall be required to:
 - (a) Notify the Department for Medicaid Services and the Social Security Administration in the appropriate county within five (5) business days of receiving notice from any source of the death of a Medicaid enrollee served by the managed care organization;
 - (b) Collaborate with the Department for Medicaid Services to implement and execute a value-based payment model that aligns incentives for enrollees, providers, managed care organizations, and the Commonwealth to improve quality and health care outcomes. The value-based payment model required under this subsection shall include a two percent (2%) withhold from each managed care organization's capitation amount that can be earned back in full or in part by the managed care organization through the achievement of designated value-based measures that shall include but not be limited to:
 1. Hospital readmission rates;
 2. Cancer screening rates;
 3. Child and adolescent well care visits;

4. Prenatal and postpartum care;
 5. Emergency department utilization rates;
 6. Behavioral health treatment and counseling services; and
 7. Recovery services; and
- (c) Comply with:
1. This section and KRS 205.533, 205.534, 205.5355(2), and 205.556;
 2. All terms, conditions, requirements, performance standards, and obligations created under or included in the contract between the managed care organization and the cabinet for the delivery of Medicaid services;
 3. KRS 304.17A-708; and
 4. All sections of Subtitle 17A of KRS Chapter 304 listed in KRS 205.522;
- (3) (a) If the Department for Medicaid Services receives mail returned as undeliverable following an attempt to contact a Medicaid beneficiary by first-class mail, the department shall make a good-faith effort to obtain the beneficiary's current and correct address. The good-faith effort shall include:
1. First, requesting the beneficiary's current and correct address from his or her managed care organization;
 2. Accessing and reviewing all available state and federal data sources, including but not limited to the National Change of Address database, from which the department might obtain the beneficiary's current and correct address; and
 3. Attempting to obtain the beneficiary's current and correct address directly from the beneficiary by attempting to contact him or her through at least two (2) of the following means of communication:
 - a. Telephone;
 - b. Text message; and
 - c. Email message.
- (b)
1. The good-faith effort required under paragraph (a) of this subsection shall continue for at least thirty (30) days after the date on which the department first requested the beneficiary's current and correct address from his or her managed care organization.
 2. If the department is able to obtain the beneficiary's current and correct address, the department shall resend any mail that was returned to the department as undeliverable.
 3. If the department is not able to obtain the beneficiary's current and correct address within thirty (30) days after the date on which the department first requested the beneficiary's current and correct address from his or her managed care organization, the department shall, to the extent permitted under federal law, disenroll the individual from the Medicaid program pending any appeal that may be required or guaranteed under federal law;

- (4) The Department for Medicaid Services shall, in all instances, exercise its rights under a contract with a Medicaid managed care organization to impose all remedies available to the department under the terms of the contract, at law, or equity if the department determines that the managed care organization or a subcontractor acting on behalf of the managed care organization has:
- (a) Violated any provision of the contract between the department and the managed care organization; or
 - (b) Failed to fully comply with any applicable state or federal law or regulation, compliance with which is mandated expressly or implicitly by the contract; and
- (5) (a) Penalties for violations of state and federal law related to the Medicaid program, including but not limited to this section, and any other contract requirements or prohibitions imposed upon the managed care organization by the cabinet, including but not limited to:
- 1. The penalty for a violation of subsection (1)(a) or (b) of this section shall be at least five hundred dollars (\$500) for each claim a managed care organization requests or incentivizes a provider to resubmit;
 - 2. The penalty for a violation of subsection (1)(c) of this section shall be at least one thousand dollars (\$1,000) per violation;
 - 3. The penalty for a violation of subsection (1)(d) of this section shall be at least five thousand dollars (\$5,000) per violation;
 - 4. The penalty for a violation of subsection (1)(e) of this section shall be at least ten thousand dollars (\$10,000) for each inactive provider included in an analysis of network adequacy; and
 - 5. The penalty for a violation of subsection (2)(a) of this section shall be at least one thousand dollars (\$1,000) per violation.
- (b) All penalties and fines imposed or assessed against a Medicaid managed care organization by the Cabinet for Health and Family Services, including but not limited to those penalties established in paragraph (a) of this subsection, shall be deposited into the Medicaid managed care organization compliance fund established in KRS 205.5357.

Effective: April 14, 2026

History: Created 2026 Ky. Acts ch. 179, sec. 10, effective April 14, 2026.