CHAPTER 139

(SCR 9)

A CONCURRENT RESOLUTION directing the Legislative Research Commission to conduct a feasibility study for an Accountable Communities for Health Medicaid delivery model pilot project.

WHEREAS, Kentucky persistently ranks among the worst states nationally for key health indicators, including chronic disease prevalence, maternal health outcomes, tobacco use, and preventable hospitalizations; and

WHEREAS, many Kentuckians are living with three or more chronic health conditions, including asthma, kidney disease, heart disease, cancer, and diabetes; and

WHEREAS, Kentucky's health issues are deeply tied to the social and economic conditions of rural communities, which remain inadequately and insufficiently addressed; and

WHEREAS, Kentucky has operated its Medicaid program primarily under a managed care delivery model since 2010; and

WHEREAS, the current Medicaid delivery model employed in the Commonwealth has failed to produce valuable outcomes as Medicaid expenditures have continued to increase while health outcomes have deteriorated and disparities have widened; and

WHEREAS, the transition from a fee-for-service Medicaid program to a managed care model was chiefly motivated by a belief that contracting with Medicaid managed care organizations to administer large portions of the Medicaid program would result in budget stability and predictability; and

WHEREAS, despite the transition to managed care under former Governor Steve Beshear, since 2010 the cost of the Kentucky Medicaid program has skyrocketed, increasing from approximately $5,900,000,000 a year in 2010 to a projected amount of over $20,600,000,000 a year in 2026; and

WHEREAS, since 2010, the number of Kentuckians enrolled in the Medicaid program has risen from roughly 920,000 to approximately 1,400,000 in 2025, an increase of roughly 50 percent resulting largely from former Governor Steve Beshear's decision to expand Medicaid eligibility under the Affordable Care Act in 2014; and

WHEREAS, expanded Medicaid eligibility and the resulting 50 percent increase in enrollment fails to explain the nearly 400 percent increase in the cost of the program over the same period of time; and

WHEREAS, the historic trend of rapid cost increases in the Medicaid program has not resulted in enhanced reimbursement rates for rural healthcare providers; and

WHEREAS, access to essential, comprehensive healthcare services in rural communities continues to erode under the managed care delivery model, underscoring the urgent need for targeted interventions to reverse this trend; and

WHEREAS, under federal law, Medicaid managed care organizations are required to achieve a minimum medical loss ratio of at least 85 percent, which means that at least 85 cents of every dollar paid to a managed care organization by a state Medicaid program must be spent on the delivery of healthcare services for Medicaid enrollees; and

WHEREAS, current contracts between the Department for Medicaid Services and the Commonwealth's five contracted Medicaid managed care organizations require managed care organizations to achieve at least a 90 percent medical loss ratio; and

WHEREAS, federal and state established medical loss ratios for Medicaid managed care organizations have the effect of limiting a managed care organization's profit from a Medicaid managed care contract to no more than 10 percent of the total contract value; and

WHEREAS, the five managed care organizations currently under contract with the Department for Medicaid Services to administer Medicaid benefits in Kentucky are all either publicly traded, for-profit corporations or owned by publicly traded, for-profit corporations; and

WHEREAS, publicly traded, for-profit corporations have a legally binding fiduciary duty to their shareholders to increase profits quarter over quarter and year over year; and

WHEREAS, existing medical loss ratio requirements effectively mean that the only way a contracted Medicaid managed care organization can fulfill its fiduciary duty to shareholders to increase profits is to see an increase in the overall cost of the Medicaid program, typically by increasing the per member per month capitation payments made by the state to the managed care organizations; and

WHEREAS, Kentucky's current health data landscape is fragmented and lacks a unified, inclusive dataset spanning the full continuum of care, limiting its effectiveness in guiding informed health policy and appropriations; and

WHEREAS, Kentucky's healthcare system remains fragmented, with hospitals, clinics, schools, social service organizations, and managed care organizations often operating in silos, which has resulted in reactive care that seeks to treat symptoms rather than coordinated strategies that tackle root causes of illness; and

WHEREAS, Kentucky must identify proven strategies to unite healthcare providers, coordinate care, and connect communities while holding the entire system accountable for both outcomes and costs; and

WHEREAS, the current cost of the Kentucky Medicaid program, paired with the historical trend of rapid cost increases, is unsustainable and represents a catastrophic threat to the stability and solvency of the Commonwealth's entire biennial budget; and

WHEREAS, given the current Medicaid landscape in Kentucky, as described above, the Commonwealth must endeavor to identify a less costly and more sustainable alternative to the current managed care delivery model; and

WHEREAS, transformative healthcare delivery models are reshaping access to care and improving health outcomes across the United States; and

WHEREAS, an increasing number of states are seeing positive results, including reduced costs and significant improvements in healthcare outcomes, by transitioning away from managed care toward an accountable care delivery model; and

WHEREAS, accountable care organizations (ACO) prioritize whole-person care, adopt value-based payment models over volume-driven approaches, and incorporate mechanisms for shared savings and financial risk; and

WHEREAS, accountable communities for health (ACH) aim to improve population health by fostering regional collaboration, investing in community-based supports, and advancing policies that promote and sustain healthier communities; and

WHEREAS, ACO and ACH models represent more strategic, provider-endorsed, community-led models that enhance health outcomes while driving cost efficiencies; and

WHEREAS, ACO and ACH models are proven Medicaid delivery models currently producing positive outcomes for state Medicaid programs across the United States and have demonstrated that smarter investments in prevention and access to care can reduce the costs of a state's Medicaid program while improving healthcare outcomes; and

WHEREAS, by implementing a comprehensive community-driven alternative healthcare delivery model that integrates physical, behavioral, and spiritual care while addressing the social conditions in which people live, work, play, and learn, the Commonwealth could realize a 20 percent improvement in both patient and provider satisfaction and significant, measurable gains in overall population health by 2030; and

WHEREAS, Kentucky's area development districts have an established track record for delivering community-based Medicaid services tailored to the needs of specific geographic regions; and

WHEREAS, Kentucky's area development districts serve a large enough population to effectively evaluate and benchmark the impact of an ACH delivery model on improving outcomes and reducing costs;

NOW, THEREFORE,

Be it resolved by the Senate of the General Assembly of the Commonwealth of Kentucky, the House of Representatives concurring therein:

➔Section 1. The Legislative Research Commission is hereby directed to conduct a feasibility study for an Accountable Communities for Health Medicaid delivery model pilot project. The feasibility study shall assess, consider, and make recommendations concerning the following:

(1) Examples of state Medicaid programs that have implemented an accountable care Medicaid delivery model, including but not limited to accountable care organizations, accountable communities for health, and

accountable health community models, to identify best practices and potential governance structure suitable for Kentucky;

(2) Opportunities, barriers, and organizational capacity for implementing an Accountable Communities for Health Medicaid delivery model pilot project under the Kentucky Medicaid program;

(3) Potential geographic regions and partners suitable for an Accountable Communities for Health Medicaid delivery model pilot project, including specific assessment of the Lincoln Trail Area Development District, Barren River Area Development District, and Green River Area Development District as an appropriate geographic region for the pilot project;

(4) Existing health information exchange, data-sharing capacity, and interoperability of various data systems, including eligibility data, across Medicaid, providers, and social service systems to identify any necessary infrastructure developments for a successful Accountable Communities for Health Medicaid delivery model pilot project;

(5) Options for financing an Accountable Communities for Health Medicaid delivery model pilot project, including anticipated costs, potential cost savings, sustainability, and funding sources with specific emphasis on identifying options for diverting current per member, per month capitation payments made to managed care organizations to the pilot project;

(6) Creation of a nonprofit mutual insurance company as an alternative to for-profit insurance companies and Medicaid managed care organizations for administering an Accountable Communities for Health Medicaid delivery model pilot project, including claims processing and provider payments;

(7) Potential pilot models, policy changes, and implementation pathways, including necessary next steps to design and implement an Accountable Communities for Health Medicaid delivery model pilot project;

(8) Strategies and metrics for evaluating the success of a future Accountable Communities for Health Medicaid delivery model pilot project, including key metrics and outcomes to be reported, monitored, and evaluated; and

(9) Any other issues or aspects of a feasibility study or an Accountable Communities for Health Medicaid delivery model pilot project determined to be necessary or appropriate by the Legislative Research Commission.

➔Section 2. The results of the feasibility study required under Section 1 of this Resolution shall be submitted to the Legislative Research Commission by November 1, 2026, for referral to the Interim Joint Committee on Health Services, the Interim Joint Committee on Appropriations and Revenue, and the Medicaid Oversight and Advisory Board.

➔Section 3. A pilot project resulting from the feasibility study required under Section 1 of this Resolution shall be known as the 20 by 30 Accountable Care Pilot Project.

➔Section 4. Provisions of this Resolution to the contrary notwithstanding, the Legislative Research Commission shall have the authority to alternatively assign the issues identified herein to an interim join committee or subcommittee thereof, and to designate a study completion date.

Signed by Governor April 13, 2026.