AN ACT relating to the Medicaid program and declaring an emergency.

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

➔Section 1. KRS 205.5372 is amended to read as follows:

(1) Notwithstanding any provision of law to the contrary, ***including but not limited to Sections 2 and 3 of this Act,*** the cabinet shall not***, unless required by federal law,*** exercise the state's option to develop a basic health program as permitted under 42 U.S.C. sec. 18051 ***or make any change to eligibility, coverage, or benefits in the Medicaid program, including by pursuing or applying for a waiver of federal Medicaid law under Title 42 of the United States Code, seeking to amend or renew an existing waiver granted under Title 42 of the United States Code, or pursuing a state plan amendment,*** without first obtaining specific authorization from the General Assembly to do so.

(2) If the cabinet seeks authorization from the General Assembly to establish a basic health program, apply for a waiver under Title 42 of the United States Code, amend an existing waiver granted under Title 42 of the United States Code, submit a state plan amendment, or make any other change to eligibility, coverage, or benefits in the Medicaid program, the cabinet shall submit a detailed assessment of the potential fiscal impact of the change for which it is seeking authorization to the Legislative Research Commission for referral to the Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Office of Budget Review. The fiscal impact assessment required by this subsection shall include a review of any anticipated expenditures related to the change and any projected savings that may be generated by the change for at least two (2) consecutive state fiscal years.

(3) If the cabinet seeks authorization from the General Assembly to renew an existing waiver granted under Title 42 of the United States Code, the cabinet shall

be required to submit a fiscal impact assessment as described in subsection (2) of this section and an assessment of the efficacy and necessity of the existing waiver. The assessments required by this subsection shall be submitted to the Legislative Research Commission for referral to the Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Office of Budget Review at least twelve (12) calendar months prior to the date on which the existing waiver is set to expire.

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

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

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

1. To comply with any requirements that may be imposed by federal law;

2. In response to a national emergency declaration issued by the President of the United States;

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

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

(b) If the cabinet determines that a change to the Medicaid program is necessary to comply with requirements imposed by federal law, the cabinet

shall, at least ninety (90) days prior to implementing the necessary changes, submit an assessment of the potential fiscal impact, as described in subsection (2) of this section, of those changes to the Legislative Research Commission for referral to the Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Office of Budget Review.

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

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

(a) Medicaid directed or supplemental payment programs initially approved by the federal Centers for Medicare and Medicaid Services prior to the effective date of this Act, including but not limited to those directed payment programs established in KRS 205.5601 to 205.5603, 205.6405 to 205.6408, and 205.6411 and 205.6412; or

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

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

➔Section 2. KRS 205.460 is amended to read as follows:

(1) The cabinet shall fund, directly or through a contracting entity or entities, in each district, a program of essential services which shall have as its primary purpose the

prevention of unnecessary institutionalization of functionally impaired elderly persons. The cabinet may use funds appropriated under this section to contract with public and private agencies, long-term care facilities, local governments, and other providers to provide core and essential services. The cabinet may provide core and essential services when such services cannot otherwise be purchased.

(2) In providing essential services, all existing community resources available to functionally impaired elderly persons shall be utilized. Additional services may be provided, but shall not be funded from funds appropriated under this section. Volunteers may be used where practicable to provide essential services to functionally impaired elderly persons. The cabinet or contracting entity shall provide or arrange for the provision of training and supervision of volunteers to ensure the delivery of quality services. The cabinet or contracting entity shall provide or arrange for appropriate insurance coverage to protect volunteers from personal liability while acting within the scope of their volunteer duties. In providing essential services under this section, the cabinet shall provide services to meet the needs of the minority elderly as identified by the cabinet pursuant to KRS 205.201.

(3) Entities contracting with the cabinet to provide essential services under KRS 205.455 and this section shall provide a minimum of fifteen percent (15%) of the funding necessary for the support of program operations. No local match is required for assessment and case management. Local contributions, whether materials, commodities, transportation, office space, personal services, or other types of facilities services, or funds may be evaluated and counted toward the fifteen percent (15%) local funding requirements.

(4) When possible, funding for core services may be obtained under:

(a) The Comprehensive Annual Social Services Program plan under Title XX of the Social Security Act;

(b) The Medical Assistance Plan under Titles XVIII and XIX of the Social Security Act;

(c) The State Plan on Aging under the Older Americans Act; or

(d) Veteran's benefit programs under the provisions of 38 U.S.C. secs. 1 et seq., as amended.

The cabinet may***, except as provided in Section 1 of this Act,*** seek federal waivers if necessary to enable the use of funds provided through Titles XVIII and XIX of the Social Security Act for the provision of essential services.

(5) Providers contracting with the cabinet to provide essential services shall be responsible for the collection of fees and contributions for services in accordance with administrative regulations promulgated by the cabinet. Providers are authorized to assess and collect fees for services rendered in accordance with those administrative regulations. To help pay for essential services received, a functionally impaired elderly person shall pay an amount of money based on an overall ability to pay in accordance with a schedule of fees established by the cabinet. Fees shall reflect the degree to which the cabinet or contracting entity uses volunteers in the provision of services. Where essential services are provided by volunteers, fees shall only be assessed in an amount that will cover the cost of materials and other goods used in the provision of services. The cost of materials and other goods used by volunteers shall be reasonably similar to the cost of goods when paid personnel are used. Fees shall not be required of any person who is "needy aged" as defined in KRS 205.010; however, voluntary contributions may be encouraged. This subsection shall not apply to programs utilizing federal funds when administrative regulations require contributions to revert to the original funding source.

➔Section 3. KRS 205.520 is amended to read as follows:

(1) KRS 205.510 to 205.630 shall be known as the "Medical Assistance Act."

(2) The General Assembly of the Commonwealth of Kentucky recognizes and declares that it is an essential function, duty, and responsibility of the state government to provide medical care to its indigent citizenry; and it is the purpose of KRS 205.510 to 205.630 to provide such care.

(3) Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may**, *except as provided in Section 1 of this Act,*** by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.

(4) It is the intention of the General Assembly to comply with the provisions of Title XIX of the Social Security Act which require that the Kentucky Medical Assistance Program recover from third parties which have a legal liability to pay for care and services paid by the Kentucky Medical Assistance Program.

(5) The Kentucky Medical Assistance Program shall be the payor of last resort and its right to recover under KRS 205.622 to 205.630 shall be superior to any right of reimbursement, subrogation, or indemnity of any liable third party.

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

(1) The cabinet, to the extent permitted under federal law, shall~~[no later than April 15, 2023,]~~ implement a community engagement program for able-bodied adults without dependents who have been enrolled in the state's medical assistance program for more than twelve (12) months.

(2) If the federal Centers for Medicare and Medicaid Services approves the implementation of a community engagement program pursuant to subsection (1) of this section:

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

sec. 273.24;

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

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

(3) ***(a) The cabinet is hereby authorized, as is required under Section 1 of this Act, and is directed to submit a waiver application to the Centers for Medicare and Medicaid Services requesting approval to establish the community engagement program for able-bodied adults without dependents described in subsections (1) and (2) of this section within ninety (90) days after the effective date of this Act.***

(b) As required in Section 6 of this Act, the cabinet shall provide a copy and summary of the waiver application submitted pursuant to this section to the Legislative Research Commission for referral to the Interim Joint Committee on Appropriations and Revenue and the Interim Joint Committee on Health Services concurrent with submitting the application to the Centers for Medicare and Medicaid Services and shall provide an update on the status of the application at least quarterly.

(4) As used in this section, "able-bodied adult without dependents" means an individual who is:

(a) Over eighteen (18) years of age but under sixty (60) years of age;

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

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

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

(1) There is hereby established within the Finance and Administration Cabinet a restricted fund to be known as the Kentucky Medicaid pharmaceutical rebate fund. All moneys received by the Cabinet for Health and Family Services or the Department for Medicaid Services as compensation or rebate, including supplemental rebates, from a pharmaceutical drug manufacturer, the state pharmacy benefit manager contracted by the department pursuant to KRS 205.5512, or any other third-party entity contracted to administer or assist in administering any aspect of the Medicaid program, minus any remittance that may be owed to the federal government, shall be deposited into the fund.

(2) KRS 45.229 notwithstanding, moneys in the Kentucky Medicaid pharmaceutical rebate fund at the close of state fiscal year 2024-2025 and state fiscal year 2025-2026 shall not lapse but shall be carried forward into the next fiscal year.

➔Section 6. KRS 205.525 is amended to read as follows:

(1) Concurrent with submitting an application for a waiver**,**~~[or]~~ waiver amendment**,** ***waiver renewal,*** or a request for a ***state*** plan amendment to any federal agency that approves waivers, waiver amendments, ***waiver renewals, or***~~[and]~~ ***state*** plan amendments, the cabinet shall provide to the Interim Joint Committee on Health Services~~[,]~~ and to the Interim Joint Committee on Appropriations and Revenue a copy, summary, and statement of benefits of the application for a waiver**,**~~[or]~~ waiver amendment***, waiver renewal,*** or request for a ***state*** plan amendment.

(2) The cabinet shall provide an update on the status of the application for a waiver**,**~~[or]~~ waiver amendment***, waiver renewal,*** or request for a ***state*** plan amendment to the Legislative Research Commission upon request.

(3) If the cabinet is expressly directed by the General Assembly to submit an application for a waiver**,**~~[or]~~ waiver amendment***, waiver renewal,*** or a request for a ***state*** plan amendment to any federal agency that approves waivers, waiver amendments, ***waiver renewals,*** or ***state*** plan amendments for public assistance

programs administered under this chapter and that application or request is denied by the federal agency, the cabinet shall notify the Legislative Research Commission of the reasons for the denial. If instructed by the General Assembly through legislative action during the next legislative session, the cabinet shall resubmit, with or without modifications based on instructions from the General Assembly, the application for a waiver**,** ~~[or]~~ waiver amendment***, waiver renewal,*** or request for a ***state*** plan amendment.

➔Section 7. KRS 205.6328 is repealed, reenacted, and amended to read as follows:

(1) ***(a) No Medicaid managed care contract shall be valid, and no payment to a Medicaid managed care vendor by the Finance and Administration Cabinet or the Cabinet for Health and Family Services shall be made, unless the Medicaid managed care contract contains a provision that the contractor shall collect Medicaid expenditure data by the categories of services paid for by the Medicaid Program. Actual statewide Medicaid expenditure data by all categories of Medicaid services, including mandated and optional Medicaid services, special expenditures and offsets, recoupments and clawbacks, and disproportionate share hospital payments by type of hospital, shall be compiled by the Department for Medicaid Services for all Medicaid providers and forwarded to the Legislative Research Commission for referral to the Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Office of Budget Review on a quarterly basis. Projections of Medicaid expenditures by categories of Medicaid services shall be provided to the Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Office of***

Budget Review upon request.

(b) Medicaid expenditure data required to be collected and reported pursuant to paragraph (a) of this subsection shall include expenditures made by any third-party administrator contracted by a managed care organization to assist in providing services and benefits to Medicaid beneficiaries, including but not limited to any dental benefit administrator, vision benefit administrator, hearing benefit administrator, or transportation benefit administrator.

(2) The Department for Medicaid Services shall submit a quarterly budget analysis report to the Legislative Research Commission for referral to the Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Office of Budget Review no later than seventy-five (75) days after the end of each quarter. The report shall provide monthly detail of actual expenditures, eligibles, and average monthly cost per eligible by eligibility category along with current trailing twelve (12) month averages for each of these figures. The report shall also provide actual figures for all categories of noneligible-specific expenditures such as supplemental medical insurance premiums, Kentucky patient access to care, nonemergency transportation, drug rebates, cost settlements, and disproportionate share hospital payments by type of hospital. The report shall compare the actual expenditure experience with those underlying the enacted or revised enacted budget and explain any significant variances which may occur.

(3) (a) Except as provided in KRS 61.878, all records and correspondence relating to Kentucky Medicaid, revenues derived from Kentucky Medicaid funds, and expenditures utilizing Kentucky Medicaid funds of a Medicaid managed care company operating within the Commonwealth shall be subject to the Kentucky Open Records Act, KRS 61.870 to 61.884. This

subsection shall not apply to any records and correspondence relating to Medicaid specifically prohibited from disclosure by the federal Health Insurance Portability and Accountability Act privacy rules.

(b) No later than sixty (60) days after the end of each quarter, each Medicaid managed care company operating within the Commonwealth shall prepare and submit to the Department for Medicaid Services sufficient information to allow the department to meet the following requirements ninety (90) days after the end of each quarter. The department shall forward to the Legislative Research Commission for referral to the Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Office of Budget Review a quarterly report detailing monthly actual expenditures by service category, monthly eligibles, and average monthly cost per eligible for Medicaid and the Kentucky Children's Health Insurance Program (KCHIP) along with current trailing twelve (12) month averages for each of these figures. The report shall also provide actual figures for other categories such as pharmacy rebates and reinsurance. Finally, the department shall include in this report the most recent information or report available regarding the amount withheld to meet Department of Insurance reserve requirements, and any distribution of moneys received or retained in excess of these reserve requirements.

(4) The Cabinet for Health and Family Services shall submit a quarterly enrollee demographics report to the Legislative Research Commission for referral to the Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Office of Budget Review no later than seventy-five (75) days after the end of each quarter. The enrollee demographics report shall provide a

summary of enrollee demographics and shall include data on at least the following demographic characteristics for enrollees by county:

(a) The total number of individuals enrolled in the Medicaid program during each month of the previous quarter by eligibility category;

(b) The number of individuals enrolled in the Medicaid program during the previous quarter with fewer than four (4) months of continuous Medicaid program coverage at the end of the previous quarter by eligibility category;

(c) 1. The number of individuals described in paragraph (b) of this subsection, by eligibility category, who had previously been disenrolled or otherwise removed from the Medicaid program for any reason during the previous seven (7) years;

2. The average number of times the individuals described in subparagraph 1. of this paragraph had been disenrolled or otherwise removed from the Medicaid program prior to the previous quarter; and

3. The average length of time in months the individuals described in subparagraph 1. of this paragraph were without Medicaid program coverage prior to their most recent enrollment into the program;

(d) The total number of individuals who were disenrolled or otherwise removed from the Medicaid program for any reason during each month of the previous quarter by eligibility category;

(e) 1. The number of individuals described in paragraph (d) of this subsection, by eligibility category, who at the time of disenrollment or removal had fewer than twelve (12) months of continuous Medicaid program coverage; and

2. The average number of times, by eligibility category, the individuals described in subparagraph 1. of this paragraph had been disenrolled

or removed from the Medicaid program during the previous seven (7) years;

(f) The number of individuals enrolled in the Medicaid program by employment status, including full-time employment, part-time employment, and unemployed;

(g) The number of individuals enrolled in the Medicaid program by race and ethnicity;

(h) The number of individuals enrolled in the Medicaid program by citizenship status, refugee status, legal immigration status, illegal or undocumented immigration status, or other status under which an individual is present in the United States;

(i) The number of beneficiaries enrolled in the Medicaid program with dependents;

(j) The total number of dependents enrolled in the Medicaid program; and

(k) Any other information or data related to Medicaid beneficiaries requested by the Legislative Research Commission.

(5) The Department for Medicaid Services shall submit a quarterly health care provider tax and assessment report to the Legislative Research Commission for referral to the Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Office of Budget Review no later than seventy-five (75) days after the end of each quarter. The health care provider tax report shall include the total amount of revenue generated during the previous quarter and the corresponding federal funding match generated during the previous quarter under:

(a) KRS 142.303;

(b) KRS 142.307;

(c) KRS 142.314;

(d) KRS 142.315;

(e) KRS 142.316;

(f) KRS 142.318;

(g) KRS 142.361;

(h) KRS 142.363;

(i) KRS 205.6406(3)(h);

(j) KRS 205.6406(3)(j);

(k) KRS 205.6412; and

(l) Any other provider tax or assessment on healthcare providers.

(6) All reports required to be submitted to the Legislative Research Commission under this section shall be submitted in a form and manner prescribed by the Legislative Research Commission.

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

~~The Cabinet for Human Resources shall establish a system for the reporting to the General Assembly, on a quarterly basis, through December 31, 1996, as to the progress in implementing the provisions of KRS 205.6310 to 205.6332, the findings of any reports or studies authorized by KRS 205.6310 to 205.6332, and recommendations regarding the reports or studies.~~

~~(2) As each item identified in subsection (1) of this section has been completed, that item shall not be included on the next quarterly report, but shall be identified as having been completed.~~

~~(3) This section expires on January 1, 1997]~~.

➔SECTION 8. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

Notwithstanding 42 C.F.R. sec. 431.17(c), all records required to be retained by 42 C.F.R. sec. 431.17(b) shall be retained by the Department for Medicaid Services for a period of not less than seven (7) years following the beneficiary's most recent disenrollment from the Medicaid program.

➔SECTION 9. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

(1) The Department for Medicaid Services and any managed care organization with whom the department contracts for the delivery of Medicaid service shall provide coverage and reimbursement for up to four hundred (400) units or one hundred (100) hours of psychoeducational services per member on an annual basis, except that the department and managed care organizations shall not be required to cover or provide reimbursement for more than four (4) units or one (1) hour of psychoeducational services per day.

(2) Notwithstanding the limitations established in subsection (1) of this section, a managed care organization may approve, cover, and provide reimbursement for more than four hundred (400) units or one hundred (100) hours of psychoeducational services per year for a Medicaid beneficiary if the managed care organization believes that the Medicaid beneficiary will receive therapeutic benefit for additional services.

(3) As used in this section, "psychoeducational services":

(a) Means direct, planned, and structured interventions that involve presenting or demonstrating information; and

(b) Includes:

1. Instruction and training services designed to increase a patient or client's knowledge and understanding of his or her psychiatric diagnosis, prognosis, treatment, and rehabilitation in order to enhance acceptance and increase cooperation and collaboration with treatment

and rehabilitation; and

2. Services billed, on or before the effective date of this Act, under HCPCS code H2027.

➔SECTION 10. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

(1) If the Cabinet for Health and Family Services believes there to be any barrier to implementing a Medicaid-related bill or resolution under consideration by the General Assembly, the cabinet shall notify the Legislative Research Commission in writing of any anticipated implementation barriers within seven (7) calendar days following a standing committee's report that the bill or resolution should pass.

(2) When the Legislative Research Commission receives written notification from the Cabinet for Health and Family Services as required by subsection (1) of this section, the written notification shall be referred to the sponsor of the bill or resolution, the committee that considered the bill or resolution, and the corresponding standing committee in the other chamber of the General Assembly.

➔Section 11. The Cabinet for Health and Family Services, Department for Medicaid Services is hereby directed to, within 90 days after the effective date of this Act, reinstate all prior authorization requirements for behavioral health services in the Medicaid program that were in place and required for behavioral health services on January 1, 2020. The Cabinet for Health and Family Services may promulgate administrative regulations necessary to comply with this section.

➔Section 12. Notwithstanding any provision of law to the contrary, the Cabinet for Health and Family Services, Department for Medicaid Services shall procure new Medicaid managed care contracts in accordance with KRS Chapter 45A. Medicaid managed care contracts procured under this section shall have an effective date of no later than January 1, 2027.

➔Section 13. The managed care organizations with whom the Department for Medicaid Services has contracted for the delivery of Medicaid services are hereby directed to collaborate with one another on the development of a scorecard for behavioral health and substance use disorder treatment services and providers to be used by all contacted managed care organizations. The scorecard collaboratively developed by the managed care organizations in accordance with this section shall be publicly available on each managed care organization's website no later than December 31, 2025.

➔Section 14. 2024 Ky. Acts ch. 173, sec. 1(186) and 2024 Ky Acts ch. 175, Part I, G., 3., b. shall serve as authorization, as required under Section 1 of this Act, for any change to eligibility, coverage, or benefits in the Medicaid program provided for in 2024 Ky. Acts ch. 173, sec. 1(186) and 2024 Ky Acts ch. 175, Part I, G., 3., b.

➔Section 15. Whereas ongoing budget negotiations at the federal level, including over federal financial support for the Medicaid program, combined with significant expansion of the Commonwealth's Medicaid budget over the last decade creates an urgent need to bolster legislative oversight of the program, an emergency is declared to exist, and this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming a law.