

FREE CONFERENCE COMMITTEE REPORT

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The Free Conference Committee on **HB 2** has met as provided in the Rules of the House and Senate and hereby reports the following to be adopted:

_____ GA X SCS _____ HCS

For the above-referenced bill, with these amendments (if applicable):

Committee (list by chamber and number): _____;

Floor (list by chamber and number): _____; and

The following Free Conference Committee action:

Beginning on page 1, after line 3, delete all language in its entirety and insert the following in lieu thereof:

" ➔Section 1. KRS 205.5371 is amended to read as follows:

- (1) (a) The cabinet~~[, to the extent permitted under federal law,]~~ shall, ***no later than January 1, 2027, for applicable individuals as defined in 42 U.S.C. sec. 1396a(xx)(9), condition eligibility for enrollment or continued enrollment in the Medicaid program on demonstrated community engagement as defined in and required under 42 U.S.C. sec. 1396a(xx)***~~[implement a mandatory community engagement waiver program for able-bodied adults without dependents who have been enrolled in the state's medical assistance program for more than twelve (12) months].~~
- (b) ***In the case of an applicable individual who is applying for enrollment in the Medicaid program, in order to be eligible for enrollment the individual shall be required to demonstrate community engagement for the month immediately preceding the month during which the individual applies for enrollment.***
- (c) ***In the case of an applicable individual who is enrolled and receiving Medicaid benefits, in order to remain eligible for continued enrollment, at the time of***

1 eligibility redetermination, the individual shall be required to demonstrate
 2 community engagement for three (3) months during the period of time since the
 3 individual's most recent eligibility determination or redetermination.

- 4 (2) Notwithstanding any provision of state law to the contrary, the cabinet shall not request
 5 an exemption, waiver, or any other delay, including but not limited to a good-faith-effort
 6 exemption, in implementing the requirements of 42 U.S.C. sec. 1396a(xx) or subsection
 7 (1) of this section that may be available to the state under 42 U.S.C. sec. 1396a(xx)(11)
 8 unless specifically authorized by the General Assembly to do so [~~If the federal Centers for~~

9 ~~Medicare and Medicaid Services approves the implementation of a mandatory community~~
 10 ~~engagement waiver program pursuant to subsection (1) of this section:~~

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

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

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

- 18 (3) ~~{(a)}~~ The cabinet shall begin, no later than September 1, 2026, providing notice to all
 19 applicable individuals, as defined in 42 U.S.C. sec. 1396a(xx)(9), of the requirement to
 20 demonstrate community engagement as established under 42 U.S.C. sec. 1396a(xx) and
 21 subsection (1) of this section. Notice provided under this subsection shall comply with
 22 the requirements of 42 U.S.C. sec. 1396a(xx)(8) [~~The cabinet is hereby authorized, as is~~

23 ~~required under KRS 205.5372, and is directed to submit a waiver application to the Centers~~
 24 ~~for Medicare and Medicaid Services requesting approval to establish the mandatory~~
 25 ~~community engagement waiver program for able bodied adults without dependents~~
 26 ~~described in subsections (1) and (2) of this section within ninety (90) days after March 27,~~
 27 ~~2025.~~

(b) ~~As required in KRS 205.525, 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 Medicaid Oversight and Advisory Board, 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) **If at any time on or after the effective date of this Act, the federal community engagement requirements established in 42 U.S.C. sec. 1396a(xx) are abolished, repealed, or otherwise diminished, the cabinet shall:**

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

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

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

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

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

2. Eligible for enrollment or currently enrolled in the Medicaid program under 42 U.S.C. sec. 1396a(a)(10)(A)(i)(VIII) or a waiver that provides coverage

1 that is equivalent to minimum essential coverage as described in Section
2 5000A(f)(1)(A) of the Internal Revenue Code of 1986; and

3 3. Not:

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

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

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

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

12 e. Medically frail or otherwise has special medical needs, including an
13 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 that
18 significantly impairs his or her ability to perform one (1) or more
19 activities of daily living; or

20 v. With a serious or complex medical condition;

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

25 g. An individual participating in a drug addiction or alcohol addiction
26 recovery program recognized by the secretary through the promulgation
27 of administrative regulations in accordance with KRS Chapter 13A;

1 *h. An inmate at a public institution;*

2 *i. Pregnant or eligible for coverage under KRS 205.592; or*

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

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

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

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

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

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

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

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

20 *7. Having a verifiable average monthly income over the previous six (6) months*
 21 *that is not less than applicable state minimum wage established in KRS*
 22 *337.275 multiplied by eighty (80) hours if the individual is a seasonal worker*
 23 *as described in Section 45R(d)(5)(B) of the Internal Revenue Code of 1986[*

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

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

27 ➔Section 2. KRS 205.6312 is amended to read as follows:

1 (1) The Department for Medicaid Services and each managed care organization contracted
 2 by the department to provide Medicaid services pursuant to this chapter shall establish
 3 cost-sharing requirements for Medicaid enrollees in accordance with this
 4 section [~~Notwithstanding any state law to the contrary, the cabinet or a managed care~~
 5 ~~organization contracted by the cabinet to provide Medicaid services pursuant to this chapter~~
 6 ~~shall not institute copayments, cost sharing, or similar charges to be paid by any medical~~
 7 ~~assistance recipients, their spouses, or parents, for any assistance provided pursuant to this~~
 8 ~~chapter, federal law, or any federal Medicaid waiver].~~

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

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

14 (b) Who are enrolled in the Medicaid program under 42 U.S.C. sec.
 15 1396a(a)(10)(A)(i)(VIII).

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

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

20 (b) Primary care services;

21 (c) Mental health care services;

22 (d) Substance use disorder services;

23 (e) Any services provided by a:

24 1. Federally-qualified health center, as defined in 42 U.S.C. sec. 1396d(l)(2);

25 2. Certified community behavioral health clinic, as defined in 42 U.S.C. sec.
 26 1396d(jj)(2); or

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

1 (f) Any other service exempted from cost-sharing requirements under federal law.

2 (4) (a) Except as provided in paragraph (b) of this subsection and subsections (3) and (5)
 3 of this section, beginning October 1, 2028, for care or an item or service furnished
 4 to a Medicaid enrolled individual described in subsection (2) of this section, the
 5 cost-sharing requirement established under this subsection shall be in the form of a
 6 copayment requirement equal to five dollars (\$5).

7 (b) The cost-sharing requirements established under this subsection for any
 8 prescription drugs shall be in the form of a copayment requirement equal to one
 9 dollar (\$1).

10 (5) The total aggregate amount of cost sharing imposed under this section for all individuals
 11 in a family shall not exceed five percent (5%) of the family's income on a monthly or
 12 quarterly basis, as determined by the secretary.

13 ➔Section 3. KRS 205.556 is amended to read as follows:

14 (1) As used in this section:

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

17 (b) "In-home program" means a program offered by a health care facility or health care
 18 professional for the treatment of substance use disorder which the insured accesses
 19 through telehealth or digital health service;

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

24 1. Clinical maternal, child, and feeding history and assessment related to
 25 breastfeeding and human lactation through the systematic collection of
 26 subjective and objective information;

27 2. Analysis of data;

- 1 3. Development of a lactation management and child feeding plan with
- 2 demonstration and instruction to parents;
- 3 4. Provision of lactation and feeding education;
- 4 5. The recommendation and use of assistive devices;
- 5 6. Communication to the primary health care practitioner or practitioners and
- 6 referral to other health care practitioners, as needed;
- 7 7. Appropriate follow-up with evaluation of outcomes; and
- 8 8. Documentation of the encounter in a patient record;
- 9 (d) "Qualified clinical lactation care practitioner" means a licensed health care
- 10 practitioner wherein lactation consultation is within their legal scope of practice; and
- 11 (e) "Telehealth" or "digital health" has the same meaning as in KRS 211.332.
- 12 (2) The Department for Medicaid Services and any managed care organization with which the
- 13 department contracts for the delivery of Medicaid services shall provide coverage:
- 14 (a) For lactation consultation;
- 15 (b) For breastfeeding equipment;
- 16 (c) To pregnant and postpartum women for an in-home program; and
- 17 (d) For telehealth or digital health services that are related to maternity care associated
- 18 with pregnancy, childbirth, and postpartum care.
- 19 (3) The coverage required by this section shall:
- 20 (a) Not be subject to:
- 21 1. Any cost-sharing requirements, including but not limited to copayments, unless
- 22 *otherwise required under federal law*; or
- 23 2. Utilization management requirements, including but not limited to prior
- 24 authorization, prescription, or referral, except as permitted in paragraph (d) of
- 25 this subsection;
- 26 (b) Be provided in conjunction with each birth for the duration of breastfeeding, as
- 27 defined by the beneficiary;

- 1 (c) For lactation consultation, include:
- 2 1. In-person, one-on-one consultation, including home visits, regardless of
- 3 location of service provision;
- 4 2. The delivery of consultation via telehealth, as defined in KRS 205.510, if the
- 5 beneficiary requests telehealth consultation in lieu of in-person, one-on-one
- 6 consultation; or
- 7 3. Group consultation, if the beneficiary requests group consultation in lieu of in-
- 8 person, one-on-one consultation; and

- 9 (d) For breastfeeding equipment, include:
- 10 1. Purchase of a single-user, double electric breast pump, or a manual pump in lieu
- 11 of a double electric breast pump, if requested by the beneficiary;
- 12 2. Rental of a multi-user breast pump on the recommendation of a licensed health
- 13 care provider; and
- 14 3. Two (2) breast pump kits as well as appropriately sized breast pump flanges and
- 15 other lactation accessories recommended by a health care provider.

16 (4) (a) The breastfeeding equipment described in subsection (3)(d) of this section shall be

17 furnished within forty-eight (48) hours of notification of need, if requested after the

18 birth of the child, or by the later of two (2) weeks before the beneficiary's expected

19 due date or seventy-two (72) hours after notification of need, if requested prior to the

20 birth of the child.

21 (b) If the department cannot ensure delivery of breastfeeding equipment in accordance

22 with paragraph (a) of this subsection, an individual may purchase equipment and the

23 department or a managed care organization with whom the department contracts for

24 the delivery of Medicaid services shall reimburse the individual for all out-of-pocket

25 expenses incurred by the individual, including any balance billing amounts.

26 ➔Section 4. KRS 205.618 is amended to read as follows:

27 (1) Notwithstanding any provision of law to the contrary, the Department for Medicaid

1 Services or a managed care organization contracted to provide Medicaid services shall, at a
2 minimum, provide coverage for all United States Food and Drug Administration-approved
3 tobacco cessation medications, all forms of tobacco cessation services recommended by the
4 United States Preventive Services Task Force, including but not limited to individual,
5 group, and telephone counseling, and any combination thereof.

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

8 (a) Counseling requirements for medication;

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

11 (c) Copayments or other out-of-pocket cost sharing, including deductibles, unless
12 otherwise required under federal law.

13 (3) Utilization management requirements, including prior authorization and step therapy, shall
14 not be imposed on any tobacco cessation services provided pursuant to this section, except
15 in the following circumstances where prior authorization may be required:

16 (a) For a treatment that exceeds the duration recommended by the most recently
17 published United States Public Health Service clinical practice guidelines on treating
18 tobacco use and dependence; or

19 (b) For services associated with more than two (2) attempts to quit within a twelve (12)
20 month period.

21 (4) Nothing in this section shall be construed to prohibit the Department for Medicaid Services
22 or a managed care organization contracted to provide Medicaid services from providing
23 coverage for tobacco cessation services in addition to those recommended or to deny
24 coverage for services that are not recommended by the United States Preventive Services
25 Task Force.

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

1 (1) Beginning January 1, 2027, the cabinet shall, in accordance with 42 U.S.C. sec.
 2 1396a(e)(14)(L), conduct Medicaid eligibility redeterminations once every six (6) months
 3 for individuals who are:

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

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

6 (2) When conducting eligibility determinations and redeterminations, including but not
 7 limited to redeterminations required under subsection (1) of this section, the cabinet
 8 shall:

9 (a) Access and review information from all available federal and state data systems
 10 that may contain information related to eligibility for enrollment or continued
 11 enrollment in the Medicaid program, including but not limited to:

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

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

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

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

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

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

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

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

6 (1) The cabinet shall:

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

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

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

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

18 2. Of the process for submitting proof of current residency to the cabinet and the
19 documents required to be submitted to validate current residency in the
20 Commonwealth; and

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

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

27 1. Disenroll the individual from the Medicaid managed care organization in

- 1 which the individual is enrolled or assigned and place the individual in the
2 Medicaid fee-for-service program; and
- 3 2. Make a second attempt to notify the individual within forty-five (45) days
4 from the date on which the notice required under paragraph (c) of this
5 subsection was made. Notifications made under this subparagraph shall
6 inform individuals:
- 7 a. That they must submit proof of current residency in the Commonwealth
8 within thirty (30) days;
- 9 b. Of the process for submitting proof of current residency to the cabinet
10 and the documents required to be submitted to validate current
11 residency in the Commonwealth; and
- 12 c. That failure to submit proof of current residency in the Commonwealth
13 within thirty (30) days shall result in the individual being disenrolled
14 from the Kentucky Medicaid program;
- 15 (e) Not make capitation payments to any managed care organization with whom the
16 cabinet contracts for the delivery of Medicaid services on behalf of any individual
17 disenrolled from managed care in accordance with paragraphs (c) and (d) of this
18 subsection;
- 19 (f) Upon receipt of a notification required under subsection (2)(b) of this section,
20 provide notice in accordance with paragraphs (c) and (d) of this subsection to the
21 individual identified by the managed care organization and disenroll the individual
22 as required under paragraphs (c) and (d) of this subsection; and
- 23 (g) Establish administrative penalties for any managed care organization that fails to
24 comply with the requirements of subsection (2) of this section;
- 25 (2) Each managed care organization with whom the cabinet contracts for the delivery of
26 Medicaid services shall:
- 27 (a) On at least a monthly basis, make all reasonable efforts to identify any individual

who is:

1. Enrolled in the Kentucky Medicaid program;

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

3. Covered by, insured by, or enrolled with the managed care organization, the managed care organization's parent company, or any subsidiary of the managed care organization or its parent company in another state, regardless of the type of coverage provided in the other state;

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

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

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

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

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

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

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

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

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

1 the Medicaid program shall receive and review information from the Department of
2 Revenue concerning individuals enrolled in the Medicaid program that may indicate a
3 change in circumstances that would affect eligibility for enrollment in the Medicaid
4 program, including but not limited to changes in adjusted gross income or family
5 composition.

6 (7) On at least a monthly basis, each enrollment or benefit tracking agency associated with
7 the Medicaid program shall receive and review information from the Department of
8 Corrections concerning individuals enrolled in the Medicaid program that may indicate
9 a change in circumstances that would affect eligibility for enrollment in the Medicaid
10 program.

11 (8) At a regularly scheduled interval, each enrollment or benefit tracking agency associated
12 with the Medicaid program shall receive and review information related to child support
13 payments received by individuals enrolled in the Medicaid program that may indicate a
14 change in circumstances that would affect eligibility for enrollment in the Medicaid
15 program.

16 (9) On at least a quarterly basis, each enrollment and benefit tracking agency associated
17 with the Medicaid program shall review information from the National Change of
18 Address database, or NCOALink, concerning individuals enrolled in the Medicaid
19 program that may indicate a change in circumstances that would affect eligibility for
20 enrollment in the Medicaid program.

21 (10) The Department for Medicaid Services shall, as permitted under federal law:

22 (a) Enter into a data exchange agreement with the Social Security Administration to
23 receive the full file of death information on at least a quarterly basis; and

24 (b) Upon receipt of the full file of death information and any update to the file,
25 disenroll from the Medicaid program any individual whose death is reported in the
26 full file of death information.

27 (11)~~(5)~~ Notwithstanding any other provision of law to the contrary:

- 1 (a) *The cabinet and* each enrollment or benefit tracking agency associated with the
 2 Medicaid program or the Supplemental Nutrition Assistance Program~~[of the cabinet]~~
 3 shall enter into a memorandum of understanding with any department, agency, or
 4 division for information detailed in this section; and
- 5 (b) Any department, agency, or division for information detailed in this section,
 6 including but not limited to the Kentucky Lottery Corporation, *the Kentucky Horse*
 7 *Racing and Gaming Corporation,* the Vital Statistics Branch, the Office of
 8 Unemployment Insurance, ~~and~~ the Department for Community Based Services, *the*
 9 *Kentucky Transportation Cabinet, the Department of Revenue, and the Department*
 10 *of Corrections,* shall enter into any necessary memoranda of understanding with the
 11 *cabinet or the* enrollment or benefit tracking agency associated with the Medicaid
 12 program or the Supplemental Nutrition Assistance Program requesting an agreement
 13 pursuant to paragraph (a) of this subsection.
- 14 ~~(12)~~~~(6)~~ *The cabinet and* each enrollment or benefit tracking agency associated with the
 15 Medicaid program or the Supplemental Nutrition Assistance Program~~[of the cabinet]~~ may
 16 contract in accordance with KRS Chapter 45A with one (1) or more independent vendors to
 17 provide additional data or information that may indicate a change in circumstances that
 18 would~~may~~ affect eligibility.
- 19 ~~(13)~~~~(7)~~ *The cabinet and* each enrollment or benefit tracking agency associated with the
 20 Medicaid program or the Supplemental Nutrition Assistance Program ~~[of the cabinet]~~ shall
 21 explore joining any multistate cooperative to identify individuals who are also enrolled in
 22 public assistance programs outside of this state.
- 23 ~~(14)~~~~(8)~~ If *the cabinet or* an enrollment or benefit tracking agency associated with the
 24 Medicaid program or the Supplemental Nutrition Assistance Program ~~[of the cabinet]~~
 25 ~~receives~~ information concerning an individual enrolled in the Medicaid program or the
 26 Supplemental Nutrition Assistance Program that indicates a change in circumstances that
 27 would~~may~~ affect eligibility, *the cabinet or* the enrollment or benefit tracking agency or

1 other appropriate agency shall:

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

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

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

- 15 1. A waiver of Supplemental Nutrition Assistance Program work requirements for
16 a county in which the unemployment rate is equal to or greater than ten percent
17 (10%);
- 18 2. A waiver of Supplemental Nutrition Assistance Program work requirements in a
19 county in which the cabinet determines that other economic conditions are
20 severe enough to necessitate a waiver; or
- 21 3. A statewide waiver of Supplemental Nutrition Assistance Program work
22 requirements if the state's unemployment rate is equal to or greater than ten
23 percent (10%).

24 (b) The cabinet shall not exercise the state's option under 7 U.S.C. sec. 2015(o)(6).

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

1 ~~(16)~~~~(10)~~ The cabinet shall, in accordance with KRS Chapter 13A, promulgate ~~all rules and~~
2 ~~administrative regulations necessary for the purposes of carrying out this section.~~

3 ~~(17)~~~~(11)~~ Upon request from the Legislative Research Commission, the cabinet ~~for Health and~~
4 ~~Family Services~~ shall submit a report relating to the number of individuals discovered
5 utilizing services inappropriately, the number of individuals who were removed from one
6 (1) or more public assistance programs as a result of a review under~~pursuant~~ to this
7 section, and the amount of public funds preserved in total and by public assistance program
8 and aggregated by prior years.

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

10 (1) As used in this section:

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

12 (b) "Period of presumptive eligibility" has the same meaning as in 42 C.F.R. sec.
13 435.1101; and

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

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

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

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

22 1. The beginning and end dates of the period of presumptive eligibility;

23 2. Notification that the individual is required to make an application for Medicaid
24 benefits through the individual's local Department for Community Based
25 Services office;

26 3. The location of the individual's local Department for Community Based
27 Services office;

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

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

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

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

15 ➔Section 9. KRS 205.200 is amended to read as follows:

16 (1) A needy aged person, a needy blind person, a needy child, a needy permanently and totally
17 disabled person, or a person with whom a needy child lives shall be eligible to receive a
18 public assistance grant only if he or she has made a proper application or an application has
19 been made on his or her behalf in the manner and form prescribed by administrative
20 regulation. No individual shall be eligible to receive public assistance under more than one
21 (1) category of public assistance for the same period of time.

22 (2) The secretary shall, by administrative regulations, prescribe the conditions of eligibility for
23 public assistance in conformity with the public assistance titles of the Social Security Act,
24 its amendments, and other federal acts and regulations. The secretary shall also promulgate
25 administrative regulations to allow for between a forty percent (40%) and a forty-five
26 percent (45%) ratable reduction in the method of calculating eligibility and benefits for
27 public assistance under Title IV-A of the Federal Social Security Act. In no instance shall

1 grants to families with no income be less than the appropriate grant maximum used for
2 public assistance under Title IV-A of the Federal Social Security Act. As used in this
3 section, "ratable reduction" means the percentage reduction applied to the deficit between
4 the family's countable income and the standard of need for the appropriate family size.

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

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

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

16 (6) The cabinet shall promptly notify the appropriate law enforcement officials of the
17 furnishing of public assistance under Title IV-A of the Federal Social Security Act in
18 respect to a child who has been deserted or abandoned by a parent.

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

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

23 (b) To accept suitable training, or

24 (c) To accept suitable employment.

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

27 (8) To the extent permitted by federal law, scholarships, grants, or other types of financial

- 1 assistance for education shall not be considered as income for the purpose of determining
2 eligibility for public assistance.
- 3 (9) To the extent permitted by federal law, any money received because of a settlement or
4 judgment in a lawsuit brought against a manufacturer or distributor of "Agent Orange" for
5 damages resulting from exposure to "Agent Orange" by a member or veteran of the Armed
6 Forces of the United States or any dependent of such person who served in Vietnam shall
7 not be considered as income for the purpose of determining eligibility or continuing
8 eligibility for public assistance and shall not be subject to a lien or be available for
9 repayment to the Commonwealth for public assistance received by the recipient.
- 10 (10) (a) For the purpose of determining eligibility for medical assistance under Title XIX of
11 the Social Security Act and compliance with 42 U.S.C. sec. 1396a(xx) and Section 1
12 of this Act, unless otherwise required by federal law, the cabinet shall only accept
13 self-attestation of income, residency, age, household composition, caretaker or
14 relative status, or receipt of other coverage as verification of last resort prior to
15 enrollment, and the cabinet shall not request federal authorization or approval to
16 waive or decline to periodically check any available income-related data source to
17 verify eligibility.
- 18 (b) This subsection shall not apply to any individual who is a resident of an assisted
19 living community as defined in KRS 194A.700 or to a long-term care facility as
20 defined in KRS 216A.010 or hospital licensed under KRS Chapter 216B that is using
21 self-attestation to determine presumptive eligibility.
- 22 (c) If an individual for medical assistance under Title XIX of the Social Security Act
23 willingly and knowingly self-attests to falsified information related to income,
24 residency, age, household composition, caretaker or relative status, or receipt of other
25 coverage, the cabinet may fine the individual not more than five hundred dollars
26 (\$500) per offense.
- 27 (11) When determining whether an applicant for services or assistance provided under this

1 chapter meets the applicable income eligibility guidelines, the cabinet shall use the most
2 recent income verification data available and consider fluctuating employment income
3 data.

4 (12) If in the normal course of operations, the cabinet finds that an individual has trafficked,
5 sold, distributed, given, or otherwise transferred an electronic benefit transfer card issued
6 by the department for money, service, or other valuable consideration, the cabinet, to the
7 extent permitted under state and federal law:

8 (a) Shall through any means practical, including but not limited to garnishment of future
9 cash assistance benefits, seek recoupment from the individual of any cash benefits
10 trafficked, sold, distributed, given, or otherwise transferred; and

11 (b) May:

12 1. Upon the first violation, deem the individual ineligible for all public assistance
13 programs administered by the cabinet under this chapter for a period of not
14 more than six (6) months;

15 2. Upon the second violation, deem the individual ineligible for all public
16 assistance programs administered by the cabinet under this chapter for a period
17 of not more than twelve (12) months; and

18 3. Upon the third violation, deem the individual ineligible for all public assistance
19 programs administered by the cabinet under this chapter for a period of not
20 more than five (5) years.

21 (13) (a) Notwithstanding any other provision of Kentucky law, the following shall be
22 disregarded for the purposes of determining an individual's eligibility for a means-
23 tested public assistance program, and the amount of assistance or benefits the
24 individual is eligible to receive under the program:

25 1. Any amount in an ABLE account;

26 2. Any contributions to an ABLE account; and

27 3. Any distribution from an ABLE account for qualified disability expenses.

1 (b) As used in~~For purposes of~~ this subsection:

- 2 1. "ABLE account" means an account established within any state having a
3 qualified ABLE program as provided in 26 U.S.C. sec. 529A, as amended;
- 4 2. "Kentucky law" includes:
- 5 a. All provisions of the Kentucky Revised Statutes;
- 6 b. Any contract to provide Medicaid managed care established pursuant to
7 this chapter;
- 8 c. Any agreement to operate a Medicaid program established pursuant to this
9 chapter; and
- 10 d. Any administrative regulation promulgated pursuant to this chapter; and
- 11 3. "Qualified disability expenses" means expenses described in 26 U.S.C. sec.
12 529A of a person who is the beneficiary of an ABLE account.

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

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

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

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

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

26 (a) Contacting or providing any incentive for Medicaid providers to resubmit claims
27 after an initial submission for the purpose of increasing the managed care

- 1 organization's risk score;
- 2 **(b) Contracting with a vendor or other subcontractor for the purpose of engaging in**
- 3 **activities the managed care organization is prohibited from engaging in under**
- 4 **paragraph (a) of this subsection;**
- 5 **(c) Penalizing a primary care provider for the primary care provider's inability to**
- 6 **make contact with a Medicaid enrollee that has been assigned to the primary care**
- 7 **provider's roster if the primary care provider has made a good-faith effort, as**
- 8 **defined by the Department for Medicaid Services in its contract with a managed**
- 9 **care organization, to contact the enrollee;**
- 10 **(d) Advertising or otherwise marketing the Medicaid program except to indicate the**
- 11 **managed care organization's participation in the Medicaid program; and**
- 12 **(e) 1. For the purposes of assessing, evaluating, or determining network adequacy,**
- 13 **counting or otherwise including in any analysis of network adequacy an**
- 14 **inactive Medicaid provider.**
- 15 **2. As used in this paragraph, "inactive Medicaid provider" means an enrolled**
- 16 **Medicaid provider who has submitted fewer than one (1) encounter or claim**
- 17 **for payment for Medicaid covered services to a given managed care**
- 18 **organization within the pervious twelve (12) months;**
- 19 **(2) The managed care organization shall be required to:**
- 20 **(a) Notify the Department for Medicaid Services and the Social Security**
- 21 **Administration in the appropriate county within five (5) business days of receiving**
- 22 **notice from any source of the death of a Medicaid enrollee served by the managed**
- 23 **care organization;**
- 24 **(b) Collaborate with the Department for Medicaid Services to implement and execute a**
- 25 **value-based payment model that aligns incentives for enrollees, providers, managed**
- 26 **care organizations, and the Commonwealth to improve quality and health care**
- 27 **outcomes. The value-based payment model required under this subsection shall**

1 include a two percent (2%) withhold from each managed care organization's
2 capitation amount that can be earned back in full or in part by the managed care
3 organization through the achievement of designated value-based measures that
4 shall include but not be limited to:

- 5 1. Hospital readmission rates;
- 6 2. Cancer screening rates;
- 7 3. Child and adolescent well care visits;
- 8 4. Prenatal and postpartum care;
- 9 5. Emergency department utilization rates;
- 10 6. Behavioral health treatment and counseling services; and
- 11 7. Recovery services; and

12 (c) Comply with:

- 13 1. This section and Sections 3, 12, 13, and subsection (2) of Section 6 of this
14 Act;
- 15 2. All terms, conditions, requirements, performance standards, and obligations
16 created under or included in the contract between the managed care
17 organization and the cabinet for the delivery of Medicaid services;
- 18 3. KRS 304.17A-708; and
- 19 4. All sections of Subtitle 17A of KRS Chapter 304 listed in KRS 205.522;

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

- 24 1. First, requesting the beneficiary's current and correct address from his or her
25 managed care organization;
- 26 2. Accessing and reviewing all available state and federal data sources,
27 including but not limited to the National Change of Address database, from

- 1 which the department might obtain the beneficiary's current and correct
2 address; and
- 3 3. Attempting to obtain the beneficiary's current and correct address directly
4 from the beneficiary by attempting to contact him or her through at least two
5 (2) of the following means of communication:
- 6 a. Telephone;
7 b. Text message; and
8 c. Email message.
- 9 (b) 1. The good-faith effort required under paragraph (a) of this subsection shall
10 continue for at least thirty (30) days after the date on which the department
11 first requested the beneficiary's current and correct address from his or her
12 managed care organization.
- 13 2. If the department is able to obtain the beneficiary's current and correct
14 address, the department shall resend any mail that was returned to the
15 department as undeliverable.
- 16 3. If the department is not able to obtain the beneficiary's current and correct
17 address within thirty (30) days after the date on which the department first
18 requested the beneficiary's current and correct address from his or her
19 managed care organization, the department shall, to the extent permitted
20 under federal law, disenroll the individual from the Medicaid program
21 pending any appeal that may be required or guaranteed under federal law;
- 22 (4) The Department for Medicaid Services shall, in all instances, exercise its rights under a
23 contract with a Medicaid managed care organization to impose all remedies available to
24 the department under the terms of the contract, at law, or equity if the department
25 determines that the managed care organization or a subcontractor acting on behalf of
26 the managed care organization has:
- 27 (a) Violated any provision of the contract between the department and the managed

1 care organization; or

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

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

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

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

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

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

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

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

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

27 (1) (a) There is hereby established in the State Treasury a restricted fund to be known as

1 the Medicaid managed care organization compliance fund.

2 (b) The fund shall consist of all penalties or fines imposed by the cabinet on a
 3 managed care organization for violations of Section 10 of this Act, any other
 4 contract violation, or any violation of state or federal law related to the Medicaid
 5 program, regardless of the manner in which the penalty of fine is paid by a
 6 managed care organization, including but not limited to reductions in future
 7 capitation payments or any monies withheld by the Department for Medicaid
 8 Services for payment of penalties or fines.

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

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

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

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

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

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

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

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

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

9 **1. Behavioral health;**

10 **2. Physical health; and**

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

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

14 **1. Internal appeals; and**

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

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

19 ➔Section 13. KRS 205.534 is amended to read as follows:

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

22 (a) Provide:

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

26 2. A toll-free telephone line for providers to submit requests for authorizations of
 27 covered services during normal business hours and extended hours in this state

- 1 on Monday and Friday through 6 p.m., including federal holidays;
- 2 3. With regard to any adverse payment or coverage determination, copies of all
3 documents, records, and other information relevant to a determination,
4 including medical necessity criteria and any processes, strategies, or evidentiary
5 standards relied upon, if requested by the provider. Documents, records, and
6 other information required to be provided under this paragraph shall be
7 provided at no cost to the provider; and
- 8 4. For any adverse payment or coverage determination, a written reply in
9 sufficient detail to inform the provider of all reasons for the determination. The
10 written reply shall include information about the provider's right to request and
11 receive at no cost to the provider documents, records, and other information
12 under subparagraph 3. of this paragraph;
- 13 (b) Afford each participating provider the opportunity for an in-person meeting with a
14 representative of the managed care organization on:
- 15 1. Any clean claim that remains unpaid in violation of KRS 304.17A-700 to
16 304.17A-730; and
- 17 2. Any claim that remains unpaid for forty-five (45) days or more after the date the
18 claim is received by the managed care organization and that individually or in
19 the aggregate exceeds two thousand five hundred dollars (\$2,500);
- 20 (c) Reprocess claims that are incorrectly paid or denied in error, in compliance with KRS
21 304.17A-708. The reprocessing shall not require a provider to rebill or resubmit
22 claims to obtain correct payment. ~~A~~~~[No]~~ claim shall ***not*** be denied for timely filing if
23 the initial claim was timely submitted;~~and~~
- 24 (d) Establish processes for internal appeals, including provisions for:
- 25 1. Allowing a provider to file any grievance or appeal related to the reduction or
26 denial of the claim within ***one hundred twenty (120)***~~[sixty (60)]~~ days of
27 ***confirmed*** receipt of a notification from the managed care organization that

1 payment for a submitted claim has been reduced or denied;~~and~~

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

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

- 9 3. *Ensuring that, following the resolution of an appeal that results in a*
10 *determination that a monetary amount is owed to a provider, payment is made*
11 *in full to the provider within thirty (30) days from the date on which the*
12 *appeal was resolved; and*

13 **(e)** *With regard to provider audits:*

14 1. *Allow at least thirty (30) calendar days for a provider to provide or grant*
15 *access to the requested records;*

16 2. *Complete an audit within one hundred eighty (18) calendar days for the data*
17 *on which the audit was initiated by the managed care organization unless the*
18 *provider subject to the audit fails to provide or grant access to requested*
19 *records in a timely manner;*

20 3. *Only recoup denied payments or issue a demand for payment from a provider*
21 *upon the final disposition of the audit, including the appeals process*
22 *established in KRS 205.646; and*

23 4. *Base recoupment of claims on the actual overpayment or underpayment of*
24 *claims unless the provider agrees to a settlement to the contrary.*

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

- 26 1. "Timely" means that an authorization or preauthorization request shall be
27 approved:

- 1 a. For an expedited authorization request, within twenty-four (24)~~seventy-~~
 2 ~~two (72)~~ hours after receipt of the request. The timeframe for an
 3 expedited authorization request may be extended by up to fourteen (14)
 4 days if:
- 5 i. The enrollee requests an extension; or
 - 6 ii. The Medicaid managed care organization justifies to the department
 7 a need for additional information and how the extension is in the
 8 enrollee's interest; and
- 9 b. For a standard authorization request, within five (5) calendar~~two (2)~~
 10 ~~business~~ days. The timeframe for a standard authorization request may be
 11 extended by up to fourteen (14) additional days if:
- 12 i. The provider or enrollee requests an extension; or
 - 13 ii. The Medicaid managed care organization justifies to the department
 14 a need for additional information and how the extension is in the
 15 enrollee's interest; and
- 16 2. a. "Expedited authorization request" means a request for authorization or
 17 preauthorization where the provider determines that following the
 18 standard~~[-a]~~ timeframe could seriously jeopardize an enrollee's life or
 19 health, or ability to attain, maintain, or regain maximum function.~~[-and]~~
- 20 b. A request for authorization or preauthorization for treatment of an enrollee
 21 with a diagnosis of substance use disorder shall be considered an
 22 expedited authorization request by the provider and the managed care
 23 organization.
- 24 (b) A decision by a managed care organization on an authorization or preauthorization
 25 request for physical, behavioral, or other medically necessary services shall be made
 26 in a timely and consistent manner so that Medicaid members with comparable
 27 medical needs receive a comparable, consistent level, amount, and duration of

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

1 organization for violation of a Medicaid managed care organization's contract relating to
 2 prompt payment of claims. The Department of Insurance shall then make a determination
 3 of whether the contract violation was also a violation of KRS 304.17A-700 to 304.17A-
 4 730.

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

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

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

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

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

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

1 fines, penalties, and sanctions, up to and including termination, as established under its
 2 Medicaid managed care contract with the department.

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

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

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

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

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

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

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

18 **a. Actuarially sound;**

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

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

25 **d. Calculated separately for each region with consideration given to each**
 26 **region's average trip time, average trip distance or average mileage per**
 27 **trip, and other region-specific factors, including but not limited to**

1 geography, terrain, and population density; and

2 (c) Require regional brokers to:

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

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

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

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

18 4. Collaborate with the Department for Medicaid Services, or another agency in
19 state government or a private entity with which the department has contracted
20 for the administration of a nonemergency medical transportation service
21 program, to implement and execute a performance-based payment model that
22 aligns incentives for Medicaid enrollees, drivers, regional brokers, and the
23 Commonwealth to improve quality, reliability, and cost-effectiveness in the
24 nonemergency medical transportation service program. The performance-
25 based payment model required under this subparagraph shall include a two
26 percent (2%) withhold from each regional broker's capitation amount that
27 can be earned back in full or in part by the regional transportation broker

1 through achievement of designated performance-based measures which shall:

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

4 b. Include but not be limited to:

5 i. Utilization rates;

6 ii. The number of nonemergency medical transportation service trips
7 completed;

8 iii. The number of nonemergency medical transportation service trips
9 canceled or rescheduled;

10 iv. The number of delayed nonemergency medical transportation
11 service trips;

12 v. Average trip time;

13 vi. Average miles per trip;

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

16 viii. Rider satisfaction.

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

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

21 (c) For the state fiscal year beginning July 1, 2028, regional brokers shall be required
22 to achieve a medical loss ratio of at least eighty-nine percent (89%).

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

26 (4) Utilization rates for nonemergency medical transportation services, including when
27 calculated by an actuary under subsection (2) of this section, shall consider only

1 nonemergency medical transportation service eligible Medicaid enrollees, as determined
2 by the Department for Medicaid Services in accordance with subsection (2)(c) of Section
3 5 of this Act, within a given region and shall not be based on the total number of
4 Medicaid enrollees.

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

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

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

18 (6) When submitting data or reports to the Department for Medicaid Services or any other
19 agency of state government with responsibility for oversight or administration of the
20 nonemergency medical transportation services, the chief executive officer, chief
21 financial officer, president, executive director, or another officer of a regional broker
22 shall attest, to the best of his or her knowledge, to the truthfulness, accuracy, and
23 completeness of all data or reports at the time of submission.

24 (7) Beginning in 2027, the Department for Medicaid Services shall conduct an annual
25 review of the nonemergency medical transportation service program and submit a report
26 to the Legislative Research Commission for referral to the Interim Joint Committees on
27 Health Services and Appropriations and Revenue and the Medicaid Oversight and

1 Advisory Board by July 1 of each year. The review and report required by this subsection
 2 shall, at a minimum, include information and recommendations for the following:

3 (a) Utilization rates;

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

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

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

8 (e) Average trip time;

9 (f) Average miles per trip;

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

12 (h) Rider satisfaction; and

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

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

17 (1) As used in this section and Section 25 of this Act:

18 (a) "Department":

19 1. Means the Department for Medicaid Services; and

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

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

25 (c) "Waiver program application" means any waiver program application, including a
 26 waiver waitlist application or application to begin receiving waiver program
 27 services.

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

6 (b) Except as provided in paragraph (c) of this subsection, the department shall not
7 place any individual on a waiver waitlist or approve any individual to receive
8 waiver program services if the individual has not completed and submitted a waiver
9 program application that includes a provider's recommendation for waiver
10 program services and provider attestation to the primary diagnosis for which the
11 individual is seeking waiver program services.

12 (c) An individual who was placed on a waiver waitlist on or before the effective date of
13 this Act shall be allowed twelve (12) months from the effective date of this Act to
14 submit a waiver program application that includes a provider's recommendation
15 for waiver program services and provider attestation to the primary diagnosis for
16 which the individual is seeking waiver program services. Any individual who was
17 placed on a waiver waitlist on or before the effective date of this Act who fails to
18 comply with the requirements of this paragraph shall be removed from the waiver
19 waitlist.

20 (d) As used in this subsection, "provider" means a physician or physician assistant
21 licensed under KRS Chapter 311, an advanced practice registered nurse licensed
22 under KRS Chapter 314, or a licensed psychologist licensed under KRS Chapter
23 319.

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

27 (a) Be nationally recognized;

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

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

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

8 (5) Notwithstanding subsections (3) and (4) of this section, an individual who is eighteen
9 (18) years of age or younger and currently receiving waiver services on the effective date
10 of this Act shall not be reassessed using the level of care assessment tools designated
11 under subsection (3) of this section and shall continue to be reassessed as required under
12 state and federal law using the assessment tool in effect on the effective date of this Act
13 until he or she reaches eighteen (18) years of age.

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

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

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

25 (c) This subsection shall not apply to:

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

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

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

10 (b) Allocation criteria developed pursuant to this subsection for the home and
11 community based waiver, or HCB waiver, shall prioritize the allocation of reserve
12 capacity waiver slots to individuals determined through assessment to be in need of
13 skilled nursing services through a waiver program.

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

25 (b) This subsection and KRS 205.8465 shall apply to area development districts, or any
26 other agency of state government, quasi-governmental agency, or private entity
27 tasked with administering or overseeing a patient directed services program under

which waiver participants are permitted to directly employ caregiving staff. Any person who knows or has reasonable cause to believe that any fraudulent activity in the hiring, employment, or compensation of patient directed services staff has occurred or is ongoing shall report or cause to be reported to the Office of Medicaid Fraud and Abuse Control.

(10) On a quarterly basis beginning July 1, 2026, the cabinet shall prepare and submit a report to the Legislative Research Commission for referral to the Interim Joint Committees on Appropriations and Revenue and Families and Children and the Medicaid Oversight and Advisory Board on waiver program expenditures and waiver service utilization rates for the quarter immediately preceding the most recent quarter.

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

(1) The General Assembly finds and declares that:

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

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

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

1 stewardship of taxpayer dollars;

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

8 (e) Existing policies and procedures for the acquisition of current and timely data,
9 evidence, records, and information by the General Assembly from the cabinet and
10 its various departments and divisions is unnecessarily bureaucratic and
11 burdensome in nature and frequently results in untimely delays that hinder the
12 General Assembly's ability to discharge its legislative duties; and

13 (f) Providing the General Assembly with continuous and ongoing access to data,
14 evidence, records, and information pertaining to the Medicaid program and the
15 administration thereof is critical to ensuring that the General Assembly is able to
16 conduct the thorough and systematic evaluations that are a necessary precursor to
17 the body's effective and meaningful discharge of its oversight, policy-making, and
18 appropriation duties.

19 (2) (a) No later than fourteen (14) calendar days after the effective date of this Act, the
20 cabinet shall provide the Commission with a comprehensive and exhaustive list of
21 all databases, datasets, electronic records, and files pertaining to the Medicaid
22 program or any aspect thereof that are maintained by or in the possession of the
23 cabinet or any of its various departments and divisions.

24 (b) No later than thirty (30) calendar days after the effective date of this Act, the
25 director of the Commission shall provide the cabinet with a list of databases,
26 datasets, electronic records, and files determined by the director to be necessary for
27 the meaningful and effective discharge of legislative duties, including oversight,

- 1 policy making, and the appropriation of funds to provide for the administration of
2 the Medicaid program by the General Assembly.
- 3 (c) No later than July 1, 2026, the cabinet shall provide the General Assembly with
4 continuous and ongoing access to all databases, datasets, electronic records, and
5 files determined by the director of the Commission to be necessary for the
6 meaningful and effective discharge of legislative duties, including oversight, policy
7 making, and the appropriation of funds to provide for the administration of the
8 Medicaid program by the General Assembly.
- 9 (3) In providing the continuous and ongoing access required under subsection (2) of this
10 section, the cabinet shall:
- 11 (a) Ensure that the director of the Commission and any nonpartisan employee thereof
12 designated by the director have electronic, machine-readable, read-only, on-
13 demand access at their regular workstations to all databases, datasets, electronic
14 records, and files determined by the director of the Commission to be necessary for
15 the meaningful and effective discharge of legislative duties by the General
16 Assembly;
- 17 (b) Consult with the director of the Commission and the Kentucky Office of
18 Information Technology on the manner and method by which access is provided;
19 and
- 20 (c) Provide training on methods to access the databases, datasets, electronic records,
21 and files in a secure manner to the director of the Commission and any
22 nonpartisan employee thereof designated by the director.
- 23 (4) The Commission and the cabinet may enter into a memorandum of understanding
24 governing the Commission's access to the shared databases, datasets, electronic records,
25 and files. Any memorandum of understanding that may be entered into under this
26 subsection:
- 27 (a) Shall not preclude or prohibit the Commission from providing information shared

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

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

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

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

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

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

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

(a) Follow-up after emergency department visits;

1 (b) Cancer screenings;

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

3 (d) Postpartum care;

4 (e) Diabetes care and management; and

5 (f) Hypertension care and management.

6 (3) The healthcare transparency dashboard shall be:

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

9 (b) Maintained and operated by the Commission.

10 ➔Section 18. KRS 7A.283 is amended to read as follows:

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

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

16 (a) The cabinet;

17 (b) The department;

18 (c) Any other state agency;

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

21 (e) The state pharmacy benefit manager contracted by the department pursuant to KRS
 22 205.5512; and

23 (f) Any other entity contracted by a state agency to administer or assist in administering
 24 any aspect of the Medicaid program or the delivery of Medicaid benefits or services;

25 (2) Establish a uniform format for reports and data submitted to the board and the frequency,
 26 which may be monthly, quarterly, semiannually, annually, or biannually, and the due date
 27 for the reports and data;

- 1 (3) Conduct public hearings in furtherance of its general duties, at which it may request the
 2 appearance of officials of any state agency and solicit the testimony of interested groups
 3 and the general public;
- 4 (4) Establish any advisory committees or subcommittees of the board that the board deems
 5 necessary to carry out its duties **and upon approval of the Commission:**
- 6 **(a) Include in the membership of an advisory committee or subcommittee individuals**
 7 **who are not members of the board; and**
- 8 **(b) Appoint as co-chairs of an advisory committee or subcommittee individuals who**
 9 **are not members of the General Assembly;**
- 10 (5) Recommend that the Auditor of Public Accounts perform a financial or special audit of the
 11 Medicaid program or any aspect thereof; and
- 12 (6) Subject to selection and approval by the ~~Legislative Research~~ Commission, utilize the
 13 services of consultants, analysts, actuaries, legal counsel, and auditors to render
 14 professional, managerial, and technical assistance, as needed.
- 15 ➔Section 19. KRS 7A.286 is amended to read as follows:
- 16 (1) The board, consistent with its purpose as established in KRS 7A.273, shall:
- 17 (a) On an ongoing basis, conduct an impartial review of all state laws and regulations
 18 governing the Medicaid program and recommend to the General Assembly any
 19 changes it finds desirable with respect to program administration, including delivery
 20 system models, program financing, benefits and coverage policies, reimbursement
 21 rates, payment methodologies, provider participation, or any other aspect of the
 22 program;
- 23 (b) On an ongoing basis, review any change or proposed change in federal laws and
 24 regulations governing the Medicaid program and report to the Legislative Research
 25 Commission on the probable costs, possible budgetary implications, potential effect
 26 on healthcare outcomes, and the overall desirability of any change or proposed
 27 change in federal laws or regulations governing the Medicaid program;

- 1 (c) At the request of the Speaker of the House of Representatives or the President of the
2 Senate, evaluate proposed changes to state laws affecting the Medicaid program and
3 report to the Speaker or the President on the probable costs, possible budgetary
4 implications, potential effect on healthcare outcomes, and overall desirability as a
5 matter of public policy;
- 6 (d) At the request of the ~~[Legislative Research]~~Commission, research issues related to
7 the Medicaid program;
- 8 (e) Beginning in 2027~~[2026]~~ and at least once every five (5) years thereafter, cause:
- 9 1. A review to be made of the administrative expenses and operational cost of the
10 Medicaid program. The review shall include but not be limited to evaluating the
11 level and growth of administrative costs, the potential for legislative changes to
12 reduce administrative costs, and administrative changes the department may
13 make to reduce administrative costs or staffing needs. At the discretion of the
14 ~~[Legislative Research]~~Commission, the review may be conducted by a
15 consultant retained by the board;
- 16 2. *A program evaluation to be conducted of the Medicaid program. In any*
17 *instance in which a program evaluation indicates inadequate operating or*
18 *administrative system controls or procedures, inaccuracies, inefficiencies,*
19 *waste, extravagance, unauthorized or unintended activities, or other*
20 *deficiencies, the board shall report its findings to the Commission. The*
21 *program evaluation shall be performed by a consultant retained by the board;*
22 *and*
- 23 3. *An actuarial analysis to be performed of the Medicaid program, to evaluate*
24 *the sufficiency and appropriateness of Medicaid reimbursement rates*
25 *established by the department and those paid by any managed care*
26 *organization contracted by the department for the delivery of Medicaid*
27 *services. The actuarial analysis shall be performed by an actuary retained by*

1 *the board;*

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

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

15 (h) ~~]Beginning in 2029 and at least once every five (5) years thereafter, cause the overall~~
 16 ~~health of the Medicaid population to be assessed. The assessment shall include but~~
 17 ~~not be limited to a review of health outcomes, healthcare disparities among program~~
 18 ~~beneficiaries and as compared to the general population, and the effect of the overall~~
 19 ~~health of the Medicaid population on program expenses. The assessment shall be~~
 20 ~~performed by a consultant retained by the board; and~~

21 ~~(g)~~(i) Beginning in 2026 and annually thereafter, publish a report covering the board's
 22 evaluations and recommendations with respect to the Medicaid program. The report
 23 shall be submitted to the ~~[Legislative Research]~~Commission no later than December
 24 1 of each year, and shall include at a minimum a summary of the board's current
 25 evaluation of the program and any legislative recommendations made by the board.

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

27 (a) Review all new or amended administrative regulations related to the Medicaid

1 program and provide comments to the Administrative Regulation Review
2 Subcommittee established in KRS 13A.020;

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

10 (c) On or before December 1 of each calendar year, adopt an annual research agenda.
11 The annual research agenda may include studies, research, and investigations
12 considered by the board to be significant. Board staff shall prepare a list of study and
13 research topics related to the Medicaid program for consideration by the board in the
14 adoption of the annual research agenda. An annual research agenda adopted by the
15 board may be amended by the ~~Legislative Research~~ Commission to include any
16 studies or reports mandated by the General Assembly during the next succeeding
17 regular session.

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

22 ➔Section 20. KRS 205.5372 is amended to read as follows:

23 (1) Notwithstanding any provision of law to the contrary, including but not limited to KRS
24 205.460 and 205.520, the cabinet shall not:~~;~~

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

27 (b) Make any change *related* to eligibility, coverage, or benefits in the Medicaid

1 program, including by pursuing or applying for a waiver of federal Medicaid law
2 under Title 42 of the United States Code, seeking to amend or renew an existing
3 waiver granted under Title 42 of the United States Code, or pursuing a state plan
4 amendment, without first obtaining specific authorization from the General Assembly
5 to do so; or

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

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

21 (3) If the cabinet seeks authorization from the General Assembly to renew an existing waiver
22 granted under Title 42 of the United States Code, the cabinet shall be required to submit a
23 fiscal impact assessment as described in subsection (2) of this section and an assessment of
24 the efficacy and necessity of the existing waiver. The assessments required by this
25 subsection shall be submitted to the Legislative Research Commission for referral to the
26 Interim Joint Committee on Appropriations and Revenue, the Interim Joint Committee on
27 Families and Children, the Interim Joint Committee on Health Services, and the Office of

1 Budget Review at least twelve (12) calendar months prior to the date on which the existing
2 waiver is set to expire.

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

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

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

12 1. To comply with any requirements that may be imposed by federal law or by the
13 federal Centers for Medicare and Medicaid Services;

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

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

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

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

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

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

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

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

11 1. Those payment programs established in KRS 205.5601 to 205.5603, 205.6405
 12 to 205.6408, 205.6411, and 205.6412, and 907 KAR 10:015 and 907 KAR
 13 10:830; and

14 2. Any other payment program for a university hospital as defined in KRS
 15 205.639; or

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

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

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

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

27 (1) **At least thirty (30) days before filing the administrative regulation with the regulations**

1 compiler, first submit the draft administrative regulation, a detailed implementation
 2 plan, and other documents required to be filed by this chapter to the Medicaid Oversight
 3 and Advisory Board established in KRS 7A.273 for review and comment; and

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

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

8 (1) Notwithstanding any provision of law to the contrary, the Department for Medicaid
 9 Services shall:

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

12 (b) Not initiate a procurement process under KRS Chapter 45A for the delivery of
 13 Medicaid Services by one (1) or more managed care organizations prior to January
 14 1, 2028.

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

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

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

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

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

26 (a) Effective management of Medicaid-covered dental services is essential for the
 27 overall health of Medicaid beneficiaries and that specialized administration of

1 dental services may improve programmatic efficiency, oral health, and overall
2 health outcomes in the Commonwealth; and

3 (b) It is the intent of the General Assembly to authorize the Department for Medicaid
4 Services to administer Medicaid-covered dental services under an administrative
5 services organization delivery model beginning January 1, 2029, and for the
6 administrative service organization contracted in accordance with this section to
7 perform administrative functions necessary to manage or process claims, prior
8 authorization requests, coordination of care, network adequacy, and customer
9 service related to Medicaid-covered dental services.

10 (2) As used in this section:

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

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

16 (3) The department shall:

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

18 1. Be licensed under KRS Chapter 313;

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

20 3. Be responsible for overseeing the administration of Medicaid-covered dental
21 services;

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

26 (c) In accordance with KRS Chapter 45A and subsection (5) of this section, select and
27 contract with a third-party ASO to administer Medicaid-covered dental services.

1 The contract entered into under this paragraph shall have an effective date of
 2 January 1, 2029;

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

5 (e) Beginning January 1, 2029:

6 1. Transition all Medicaid beneficiaries from Medicaid managed care
 7 organization coverage into ASO coverage for the administration of all
 8 Medicaid-covered dental services; and

9 2. Establish a Dental Services Advisory Panel which shall:

10 a. Include the following members:

11 i. The Medicaid dental director employed pursuant to paragraph (a)
 12 of this subsection;

13 ii. The members of Technical Advisory Committee on Dental Care
 14 established in KRS 205.590; and

15 iii. A representative from the ASO contracted with pursuant to
 16 paragraph (c) of this subsection;

17 b. Be attached to the department for administrative purposes; and

18 c. Provide ongoing consultation, recommendations, and guidance to the
 19 department to continually improve administration and delivery of
 20 Medicaid-covered dental services; and

21 (f) On January 1, 2029, begin utilizing an ASO delivery model for the administration
 22 of all Medicaid-covered dental services.

23 (4) (a) The ASO contracted with pursuant to this section shall operate on an
 24 administrative-services-only basis. The ASO shall not assume any financial or
 25 insurance risk for the cost of dental claims incurred by the Commonwealth, and
 26 the Commonwealth shall remain fully financially responsible for all Medicaid-
 27 covered dental claims.

1 (b) The duties and responsibilities of the ASO contracted with pursuant to this section
2 shall be limited to the following administrative services:

3 1. Assisting with and facilitating the transitioning of all Medicaid beneficiaries
4 from Medicaid managed care organization coverage into ASO coverage for
5 dental services;

6 2. Processing and paying Medicaid-covered dental services claims in accordance
7 with the department's established fee schedule and clinical guidelines;

8 3. Employing utilization control strategies established by the department and
9 managing all prior authorization requests for Medicaid-covered dental
10 services;

11 4. Providing coordination of care with a Medicaid beneficiary's Medicaid
12 managed care organization;

13 5. Providing customer service and support to Medicaid beneficiaries and
14 Medicaid-participating dental providers; and

15 6. Any other administrative duties or responsibilities contractually assigned to
16 the ASO by the department.

17 (c) The ASO contracted with pursuant to this section shall not include in any analysis
18 of network adequacy an inactive Medicaid provider as defined in Section 10 of this
19 Act;

20 (5) (a) Notwithstanding any provision of law to the contrary including subsection (3)(c) of
21 this section, the department shall not initiate a procurement process to contract
22 with a third-party ASO to administer Medicaid-covered dental services prior to
23 January 1, 2028.

24 (b) Any contract entered into under this section shall be submitted to the Government
25 Contract Review Committee of the Legislative Research Commission for comment
26 and review.

27 (6) On an annual basis, the department, in collaboration with the Dental Services Advisory

1 **Panel, shall:**

2 **(a) Evaluate the dental ASO's performance based on metrics, including but not limited**
 3 **to the following:**

4 **1. Accuracy and timeliness of claims processing;**

5 **2. Efficiency of processing prior authorization requests;**

6 **3. Observed network adequacy improvements;**

7 **4. Availability of and access to services; and**

8 **5. Satisfaction ratings from participating dental service providers and Medicaid**
 9 **beneficiaries; and**

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

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

15 205.515 Medicaid program delivery system.

16 311A.172 Provision of nonemergency medical transportation services to a resident by a skilled
 17 nursing facility or hospital -- Conditions.

18 ➔Section 26. (1) The Medicaid Oversight and Advisory Board is hereby directed to
 19 establish a Waiver Waitlist Management Subcommittee during the 2026 Legislative Interim. The
 20 Waiver Waitlist Management Subcommittee shall:

21 (a) Review the current state of 1915(c) Home and Community Based Waiver program
 22 waitlists;

23 (b) Consider strategies implemented by other states to manage demand for 1915(c)
 24 waiver services;

25 (c) Assess the potential of a tier priority system for assigning waiver slots based on
 26 acuity of need to reduce the number of individuals on waiver waitlists;

27 (d) Receive testimony and reports from the Cabinet for Health and Family Services

1 related to waiver waitlist management strategies required under subsection (2) of this Section;

2 (e) Make recommendations for strategies that have the potential to reduce the number of
3 individuals on waiver waitlists.

4 (2) The Cabinet for Health and Family Services is hereby direct to prepare and submit a
5 report to the Medicaid Oversight and Advisory Board by October 1, 2026. The report required
6 under this subsection shall include:

7 (a) A review of potential strategies for reducing the number of individuals currently on
8 the waiver waitlists; and

9 (b) A proposal for implementing a tiered priority system for assigning a priority level for
10 each waiver program applicant and assigning waiver slots on the basis of the tiered priority
11 system.

12 (3) The Waiver Waitlist Management Subcommittee of the Medicaid Oversight and
13 Advisory Board shall submit its findings and recommendations to the Legislative Research
14 Commission no later than December 1, 2026.

15 ➔Section 27. If the Cabinet for Health and Family Services or the Department for
16 Medicaid Services determines that a state plan amendment, waiver, or any other form of
17 authorization or approval from any federal agency to implement Sections 1, 2, 3, 4, 5, 6, 7, 8, 9,
18 10, 11, 13, 14, or 15 of this Act is necessary to prevent the loss of federal funds or to comply
19 with federal law, the cabinet or department:

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

23 (2) May only delay implementation of the provisions of Sections 1, 2, 3, 4, 5, 6, 7, 8, 9,
24 10, 11, 13, 14, and 15 of this Act for which federal authorization or approval was deemed
25 necessary until the federal authorization or approval is granted.

26 ➔Section 28. Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, and 27 of this Act shall
27 constitute the specific authorization required under KRS 205.5372(1).

1 ➔Section 29. The Medicaid Oversight and Advisory Board, established in KRS 7A.273,
2 is hereby directed to evaluate the Medicaid nonemergency medical transportation, or NEMT,
3 program during the 2026 Legislative Interim. As part of the evaluation directed by this section
4 the board shall:

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

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

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

12 (b) The regional broker system; and

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

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

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

18 (5) Identify strategies to:

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

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

21 (c) Improve customer satisfaction; and

22 (d) Enhance administrative efficiencies; and

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

25 ➔Section 30. Provisions of Section 26 and 29 of this Act to the contrary notwithstanding,
26 the Legislative Research Commission shall have the authority to alternatively assign the issues
27 identified therein to an interim joint committee or subcommittee thereof, and to designate a study

1 completion date.

2 →Section 31. Sections 26, 29, and 30 of this Act shall have the same legal status as a
3 House Concurrent Resolution.

4 →Section 32. (1) There is included in the Medicaid Administration Budget Unit in the
5 2026-2028 State/Executive Branch Budget enacted in 2026 RS HB 500 sufficient funds to
6 implement a community engagement pilot program for Medicaid enrolled individuals who are
7 subject to newly established federal demonstrated community engagement requirements, and the
8 Cabinet for Health and Family Services shall distribute \$5,000,000 in each fiscal year of the
9 2026-2028 fiscal biennium to Volunteers of America to support implementation and
10 administration of the community engagement pilot program described in this section.

11 (2) The community engagement pilot program shall:

12 (a) Be implemented by Volunteers of America, or its direct successor;

13 (b) Utilize a coordinated case management technology platform capable of tracking
14 eligibility, participation, exemptions, compliance, outcomes, and real-time communication
15 between partners;

16 (c) Be implemented through a proven community alliance model that operates at the
17 local, county, level and integrate workforce, education, health, faith-based, nonprofit, and social
18 service partners;

19 (d) Provide individualized participant navigation, coaching, and support services
20 designed to promote sustained employment, education, training, or community engagement;

21 (e) Collect data necessary to support future statewide implementation and meet federal
22 reporting requirements for demonstrated community engagement; and

23 (f) Begin providing services, no later than January 1, 2027, to Medicaid enrolled
24 individuals within pilot site areas who are subject to federally established demonstrated
25 community engagement requirements.

26 (3) The purpose of the pilot program shall be to:

27 (a) Establish the operational, technological, and community infrastructure groundwork

1 for full-scale federally required demonstrated community engagement compliance by January 1,
2 2027; and

3 (b) Provide wraparound services and supports to Medicaid enrolled individuals who are
4 subject to federal demonstrated community engagement requirements to promote workforce
5 participation and self-sufficiency.

6 (4) Volunteers of America shall:

7 (a) Collaborate with community organizations within pilot site areas including but not
8 limited to Appalachian Regional Healthcare, Eastern Kentucky Concentrated Employment
9 Program, Family Scholar House, and KentuckianaWorks; and

10 (b) Submit quarterly reports beginning October 1, 2026, to the Legislative Research
11 Commission for referral to the Medicaid Oversight and Advisory Board and the Interim Joint
12 Committee on Appropriations and Revenue. The quarterly reports required under this subsection
13 shall include information on enrollment, compliance rates, outcomes, pilot program
14 expenditures, and readiness benchmarks for statewide implementation.

15 ➔Section 32. Whereas recently enacted federal changes to the Medicaid program and
16 significant increases in the Commonwealth's Medicaid budget over the last decade create an
17 urgent need to bolster legislative oversight of the Medicaid program, take immediate steps to
18 comply with new federal requirements, and ensure that Medicaid expenditures support the
19 healthcare needs of only those individuals the program is intended to serve, an emergency is
20 declared to exist, and this Act takes effect upon its passage and approval by the Governor or
21 upon its otherwise becoming a law."
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Senate Members

House Members

The above-named members, in separate votes by house, all concur in the provisions of this report.

DATE

For Clerk's Use:

Adopted: _____

Repassage Vote: _____