

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1986; and

3. Not:

- a. Currently, or was not previously, placed in the foster care system if the individual is under twenty-six (26) years of age;
- b. Eligible for coverage under the Indian Health Service;
- c. A parent, guardian, caretaker relative, or family caregiver, as defined in the RAISE Family Caregivers Act, Pub. L. No. 115-119, of a dependent child thirteen (13) years of age or under or a disabled individual;
- d. A disabled veteran with a disability rated as total under 38 U.S.C. sec. 1155;
- e. Medically frail or otherwise has special medical needs, including an individual:
 - i. Who is blind or disabled;
 - ii. With a substance use disorder;
 - iii. With a disabling mental condition;
 - iv. With a physical, intellectual, or developmental disability that significantly impairs his or her ability to perform one (1) or more activities of daily living; or
 - v. With a serious or complex medical condition;
- f. An individual subject to work or community engagement requirements imposed under the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families, if the individual is in compliance with such requirements;
- g. An individual participating in a drug addiction or alcohol addiction recovery program recognized by the secretary through

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

3 h. An inmate at a public institution;

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

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

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

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

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

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

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

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

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

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

1 *the Internal Revenue Code of 1986*

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

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

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

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

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

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

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

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

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

26 *(b) Primary care services;*

27 *(c) Mental health care services;*

1 (d) Substance use disorder services;

2 (e) Any services provided by a:

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

4 1396d(l)(2);

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

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

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

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

9 law.

10 (4) Except as provided in subsections (3) and (6) of this section, beginning January

11 1, 2027, through September 30, 2028, the following cost-sharing requirements

12 shall be imposed against Medicaid enrolled individuals described in subsection

13 (2) of this section:

14 (a) Nonemergency use of a hospital emergency department shall be subject to a

15 copayment of eight dollars (\$8). Copayments established under this

16 paragraph shall:

17 1. Only apply to nonemergency services as defined in 42 C.F.R. sec.

18 447.51;

19 2. Not apply to any emergency service as defined in 42 C.F.R. sec.

20 438.114;

21 3. Not apply to any service furnished in a hospital emergency department

22 that is required to be provided as an appropriate medical screening

23 examination or stabilizing examination and treatment under 42 U.S.C.

24 sec. 1395dd; and

25 4. Not be applied on the basis of lists of diagnoses or symptoms; and

26 (b) Inpatient hospital services shall be subject to a copayment of thirty-five

27 dollars (\$35).

1 (5) (a) Except as provided in paragraphs (b) and (c) of this subsection and
 2 subsection (3) and (6) of this section, beginning October 1, 2028, for care or
 3 an item or service furnished to a Medicaid enrolled individual described in
 4 subsection (2) of this section, the cost-sharing requirement established
 5 under this subsection shall be in the form of a copayment requirement
 6 equal to twenty dollars (\$20).

7 (b) The cost-sharing requirement established under this subsection for
 8 inpatient stays shall be in the form of a copayment requirement equal to
 9 thirty-five dollars (\$35).

10 (c) The cost-sharing requirements established under this subsection for
 11 prescription drugs shall be in the form of a copayment requirement equal to
 12 one dollar (\$1) for preferred drugs, as defined in 42 C.F.R. sec. 447.51, and
 13 five dollars (\$5) for nonpreferred drugs.

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

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

18 (1) As used in this section:

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

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

24 (c) "Lactation consultation" means the clinical application of scientific principles
 25 and a multidisciplinary body of evidence for evaluation, problem
 26 identification, treatment, education, and consultation to families regarding the
 27 course of lactation and feeding by a qualified clinical lactation care

- 1 practitioner, including but not be limited to:
- 2 1. Clinical maternal, child, and feeding history and assessment related to
 - 3 breastfeeding and human lactation through the systematic collection of
 - 4 subjective and objective information;
 - 5 2. Analysis of data;
 - 6 3. Development of a lactation management and child feeding plan with
 - 7 demonstration and instruction to parents;
 - 8 4. Provision of lactation and feeding education;
 - 9 5. The recommendation and use of assistive devices;
 - 10 6. Communication to the primary health care practitioner or practitioners
 - 11 and referral to other health care practitioners, as needed;
 - 12 7. Appropriate follow-up with evaluation of outcomes; and
 - 13 8. Documentation of the encounter in a patient record;
- 14 (d) "Qualified clinical lactation care practitioner" means a licensed health care
- 15 practitioner wherein lactation consultation is within their legal scope of
- 16 practice; and
- 17 (e) "Telehealth" or "digital health" has the same meaning as in KRS 211.332.
- 18 (2) The Department for Medicaid Services and any managed care organization with
- 19 which the department contracts for the delivery of Medicaid services shall provide
- 20 coverage:
- 21 (a) For lactation consultation;
 - 22 (b) For breastfeeding equipment;
 - 23 (c) To pregnant and postpartum women for an in-home program; and
 - 24 (d) For telehealth or digital health services that are related to maternity care
 - 25 associated with pregnancy, childbirth, and postpartum care.
- 26 (3) The coverage required by this section shall:
- 27 (a) Not be subject to:

- 1 1. Any cost-sharing requirements, including but not limited to copayments,
2 *unless otherwise required under federal law*; or
3 2. Utilization management requirements, including but not limited to prior
4 authorization, prescription, or referral, except as permitted in paragraph
5 (d) of this subsection;
- 6 (b) Be provided in conjunction with each birth for the duration of breastfeeding,
7 as defined by the beneficiary;
- 8 (c) For lactation consultation, include:
- 9 1. In-person, one-on-one consultation, including home visits, regardless of
10 location of service provision;
- 11 2. The delivery of consultation via telehealth, as defined in KRS 205.510,
12 if the beneficiary requests telehealth consultation in lieu of in-person,
13 one-on-one consultation; or
- 14 3. Group consultation, if the beneficiary requests group consultation in lieu
15 of in-person, one-on-one consultation; and
- 16 (d) For breastfeeding equipment, include:
- 17 1. Purchase of a single-user, double electric breast pump, or a manual
18 pump in lieu of a double electric breast pump, if requested by the
19 beneficiary;
- 20 2. Rental of a multi-user breast pump on the recommendation of a licensed
21 health care provider; and
- 22 3. Two (2) breast pump kits as well as appropriately sized breast pump
23 flanges and other lactation accessories recommended by a health care
24 provider.
- 25 (4) (a) The breastfeeding equipment described in subsection (3)(d) of this section
26 shall be furnished within forty-eight (48) hours of notification of need, if
27 requested after the birth of the child, or by the later of two (2) weeks before

1 the beneficiary's expected due date or seventy-two (72) hours after
2 notification of need, if requested prior to the birth of the child.

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

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

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

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

19 (a) Counseling requirements for medication;

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

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

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

- 1 (a) For a treatment that exceeds the duration recommended by the most recently
 2 published United States Public Health Service clinical practice guidelines on
 3 treating tobacco use and dependence; or
- 4 (b) For services associated with more than two (2) attempts to quit within a
 5 twelve (12) month period.
- 6 (4) Nothing in this section shall be construed to prohibit the Department for Medicaid
 7 Services or a managed care organization contracted to provide Medicaid services
 8 from providing coverage for tobacco cessation services in addition to those
 9 recommended or to deny coverage for services that are not recommended by the
 10 United States Preventive Services Task Force.

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

13 **(1) Notwithstanding 42 U.S.C. sec. 1396a(e)(14)(L)(i), the cabinet shall, no later than**
 14 **July 1, 2026, begin conducting Medicaid eligibility redeterminations once every**
 15 **six (6) months for individuals who are:**

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

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

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

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

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

25 **2. The Transformed Medicaid Statistical Information System, or T-**
 26 **MSIS;**

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

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

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

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

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

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

19 (1) The cabinet shall:

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

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

26 (c) Notify any individual suspected of being concurrently enrolled in the
 27 Kentucky Medicaid program and one (1) or more other states' Medicaid

1 programs within thirty (30) days of identification under paragraph (b) of
2 this subsection. Notifications made under this paragraph shall inform
3 individuals:

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

6 2. Of the process for submitting proof of current residency to the cabinet
7 and the documents required to be submitted to validate current
8 residency in the Commonwealth; and

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

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

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

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

22 a. That they must submit proof of current residency in the
23 Commonwealth within thirty (30) days;

24 b. Of the process for submitting proof of current residency to the
25 cabinet and the documents required to be submitted to validate
26 current residency in the Commonwealth; and

27 c. That failure to submit proof of current residency in the

1 Commonwealth within thirty (30) days shall result in the
2 individual being disenrolled from the Kentucky Medicaid
3 program;

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

8 (f) Upon receipt of a notification required under subsection (2)(b) of this
9 section, provide notice in accordance with paragraphs (c) and (d) of this
10 subsection to the individual identified by the managed care organization
11 and disenroll the individual as required under paragraphs (c) and (d) of this
12 subsection; and

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

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

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

19 1. Enrolled in the Kentucky Medicaid program;

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

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

27 (b) Promptly notify the cabinet of any individual identified in accordance with

- 1 paragraph (a) of this subsection; and
 2 (c) On a monthly basis, report to the Department for Medicaid Services efforts
 3 and activities undertaken to comply with paragraph (a) of this subsection;
 4 and
 5 (3) (a) The cabinet shall impose a penalty of one thousand dollars (\$1,000) for
 6 each violation of:
 7 1. Subsection (2)(a) and (c) of this section with each month in which a
 8 managed care organization fails to comply with subsection (2)(a) and
 9 (c) of this section constituting a separate violation; and
 10 2. Subsection (2)(b) of this section.
 11 (b) Penalties collected under this subsection shall be deposited into the
 12 Medicaid managed care organization compliance fund established in
 13 Section 11 of this Act.

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

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

1 circumstances that ~~would~~^{may} affect eligibility.

2 (3) On at least a quarterly basis, each enrollment or benefit tracking agency associated
3 with the Medicaid program or the Supplemental Nutrition Assistance Program of
4 the cabinet shall receive and review information from the ~~Kentucky~~ Office of
5 Unemployment Insurance concerning individuals enrolled in the Medicaid program
6 or the Supplemental Nutrition Assistance Program that may indicate^{indicates} a
7 change in circumstances that ~~would~~^{may} affect eligibility, including but not
8 limited to changes in employment or wages.

9 (4) On at least a quarterly basis, each enrollment or benefit tracking agency associated
10 with the Medicaid program or the Supplemental Nutrition Assistance Program of
11 the cabinet shall receive and review information, including information from the
12 Kentucky Transitional Assistance Program, concerning individuals enrolled in the
13 Medicaid program or the Supplemental Nutrition Assistance Program that may
14 indicate^{indicates} a change in circumstances that ~~would~~^{may} affect eligibility,
15 including but not limited to potential changes in residency as identified by out-of-
16 state electronic benefit transfer transactions.

17 (5) On at least a quarterly basis, each enrollment and benefit tracking agency
18 associated with the Medicaid program shall receive and review information from
19 the Kentucky Transportation Cabinet, including vehicle registration information,
20 concerning individuals enrolled in the Medicaid program that may indicate a
21 change in circumstances that would affect eligibility for Medicaid-covered
22 nonemergency medical transportation services.

23 (6) On at least an annual basis, each enrollment or benefit tracking agency
24 associated with the Medicaid program shall receive and review information from
25 the Department of Revenue concerning individuals enrolled in the Medicaid
26 program that may indicate a change in circumstances that would affect eligibility
27 for enrollment in the Medicaid program, including but not limited to changes in

1 adjusted gross income or family composition.

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

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

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

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

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

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

24 ~~(11)(5)~~ Notwithstanding any other provision of law to the contrary:

25 (a) The cabinet and each enrollment or benefit tracking agency associated with
 26 the Medicaid program or the Supplemental Nutrition Assistance Program ~~of~~
 27 ~~the cabinet~~ shall enter into a memorandum of understanding with any

1 department, agency, or division for information detailed in this section; and

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

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

17 ~~(13)~~~~(7)~~ *The cabinet and* each enrollment or benefit tracking agency associated with
 18 the Medicaid program or the Supplemental Nutrition Assistance Program ~~of the~~
 19 ~~cabinet~~ shall explore joining any multistate cooperative to identify individuals who
 20 are also enrolled in public assistance programs outside of this state.

21 ~~(14)~~~~(8)~~ If *the cabinet or* an enrollment or benefit tracking agency associated with the
 22 Medicaid program or the Supplemental Nutrition Assistance Program ~~of the~~
 23 ~~cabinet~~ receives information concerning an individual enrolled in the Medicaid
 24 program or the Supplemental Nutrition Assistance Program that indicates a change
 25 in circumstances that would~~may~~ affect eligibility, *the cabinet or* the enrollment or
 26 benefit tracking agency or other appropriate agency shall:

27 *(a) For individuals enrolled in the Supplemental Nutrition Assistance Program,*

1 review the individual's case; and

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

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

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

22 (b) The cabinet shall not exercise the state's option under 7 U.S.C. sec.
 23 2015(o)(6).

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

27 (16) (a) Unless expressly required under federal law or as permitted under

1 paragraph (b) of this subsection, the cabinet shall not seek or request a
 2 short-term hardship exemption or waiver related to county unemployment
 3 rates as permitted under 42 U.S.C. sec. 1396a(xx)(3)(B)(ii)(II)(bb) without
 4 first obtaining specific authorization from the General Assembly to do so.

5 (b) The cabinet may, without first obtaining specific authorization from the
 6 General Assembly, seek or request a short-term hardship exemption or
 7 waiver under 42 U.S.C. sec. 1396a(xx)(3)(B)(ii)(II)(bb) for a county in
 8 which the unemployment rate is equal to or greater than ten percent (10%).

9 ~~(17)~~~~(10)~~ The cabinet shall, in accordance with KRS Chapter 13A, promulgate ~~all rules~~
 10 ~~and~~ administrative regulations necessary for the purposes of carrying out this
 11 section.

12 ~~(18)~~~~(11)~~ Upon request from the Legislative Research Commission, the cabinet ~~for~~
 13 ~~Health and Family Services~~ shall submit a report relating to the number of
 14 individuals discovered utilizing services inappropriately, the number of individuals
 15 who were removed from one (1) or more public assistance programs as a result of a
 16 review under~~pursuant~~ to this section, and the amount of public funds preserved in
 17 total and by public assistance program and aggregated by prior years.

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

19 (1) As used in this section:

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

21 (b) "Period of presumptive eligibility" has the same meaning as in 42 C.F.R. sec.
 22 435.1101; and

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

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

27 (a) Notify the department of the determination within five (5) business days from

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

- 1 (a) The reason for the determination;
- 2 (b) Notification that the individual may file a full Medicaid application through
3 the individual's local Department for Community Based Services office if the
4 individual wishes to have a formal determination of eligibility made by the
5 department; and
- 6 (c) The location of the individual's local Department for Community Based
7 Services office.
- 8 (4) Notwithstanding any other provision of law to the contrary and to the extent
9 permitted under federal law, a pregnant individual shall be limited to one (1) period
10 of presumptive eligibility per pregnancy.
- 11 (5) (a) The department shall provide training on all applicable state and federal laws
12 related to presumptive eligibility to all qualified hospitals.
- 13 (b) Prior to conducting presumptive eligibility screenings and determinations, a
14 qualified hospital's staff, contractor, or vendor responsible for presumptive
15 eligibility screenings and determinations shall be required to complete
16 presumptive eligibility training provided by the department.
- 17 (6) If a qualified hospital uses a contractor or other vendor for the purpose of
18 conducting presumptive eligibility screenings and determinations, the hospital shall
19 be responsible for monitoring the contractor's or vendor's compliance with all
20 applicable state and federal laws related to presumptive eligibility.
- 21 (7) ~~Within ninety (90) days after July 14, 2022,~~ The department shall promulgate
22 administrative regulations in accordance with KRS Chapter 13A that are necessary
23 to administer this section. Administrative regulations promulgated pursuant to this
24 subsection shall include but not be limited to a thorough presumptive eligibility
25 application form to be used by qualified hospitals when making presumptive
26 eligibility determinations using information provided and attested to by an
27 individual.

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

- 2 (1) A needy aged person, a needy blind person, a needy child, a needy permanently and
3 totally disabled person, or a person with whom a needy child lives shall be eligible
4 to receive a public assistance grant only if he or she has made a proper application
5 or an application has been made on his or her behalf in the manner and form
6 prescribed by administrative regulation. No individual shall be eligible to receive
7 public assistance under more than one (1) category of public assistance for the same
8 period of time.
- 9 (2) The secretary shall, by administrative regulations, prescribe the conditions of
10 eligibility for public assistance in conformity with the public assistance titles of the
11 Social Security Act, its amendments, and other federal acts and regulations. The
12 secretary shall also promulgate administrative regulations to allow for between a
13 forty percent (40%) and a forty-five percent (45%) ratable reduction in the method
14 of calculating eligibility and benefits for public assistance under Title IV-A of the
15 Federal Social Security Act. In no instance shall grants to families with no income
16 be less than the appropriate grant maximum used for public assistance under Title
17 IV-A of the Federal Social Security Act. As used in this section, "ratable reduction"
18 means the percentage reduction applied to the deficit between the family's
19 countable income and the standard of need for the appropriate family size.
- 20 (3) The secretary may by administrative regulation prescribe as a condition of
21 eligibility that a needy child regularly attend school, and may further by
22 administrative regulation prescribe the degree of relationship of the person or
23 persons in whose home such needy child must reside.
- 24 (4) The secretary may by administrative regulation prescribe conditions for bringing
25 paternity proceedings or actions for support in cases of out of wedlock birth or
26 nonsupport by a parent in the public assistance under Title IV-A of the Federal
27 Social Security Act program.

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

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

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

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

11 (b) To accept suitable training, or

12 (c) To accept suitable employment.

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

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

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

26 (10) (a) For the purpose of determining eligibility for medical assistance under Title
27 XIX of the Social Security Act, and compliance with 42 U.S.C. sec.

1 **1396a(xx) and Section 1 of this Act**, unless otherwise required by federal law,
2 the cabinet shall:

3 1. Only accept self-attestation of [~~income, residency, age,~~] household
4 composition, caretaker or relative status, or receipt of other coverage as
5 verification of last resort prior to enrollment; [~~and the cabinet shall~~]

6 **2. Not, in any circumstance, accept self-attestation of income, residency,**
7 **or age; and**

8 3. Not request federal authorization or approval to waive or decline to
9 periodically check any available income-related data source to verify
10 eligibility.

11 (b) This subsection shall not apply to any individual who is a resident of an
12 assisted living community as defined in KRS 194A.700 or to a long-term care
13 facility as defined in KRS 216A.010 or hospital licensed under KRS Chapter
14 216B that is using self-attestation to determine presumptive eligibility.

15 (c) If an individual for medical assistance under Title XIX of the Social Security
16 Act willingly and knowingly self-attests to falsified information related to
17 [~~income, residency, age,~~] household composition, caretaker or relative status,
18 or receipt of other coverage, the cabinet may fine the individual not more than
19 five hundred dollars (\$500) per offense.

20 (11) When determining whether an applicant for services or assistance provided under
21 this chapter meets the applicable income eligibility guidelines, the cabinet shall use
22 the most recent income verification data available and consider fluctuating
23 employment income data.

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

- 1 (a) Shall through any means practical, including but not limited to garnishment of
2 future cash assistance benefits, seek recoupment from the individual of any
3 cash benefits trafficked, sold, distributed, given, or otherwise transferred; and
- 4 (b) May:
- 5 1. Upon the first violation, deem the individual ineligible for all public
6 assistance programs administered by the cabinet under this chapter for a
7 period of not more than six (6) months;
 - 8 2. Upon the second violation, deem the individual ineligible for all public
9 assistance programs administered by the cabinet under this chapter for a
10 period of not more than twelve (12) months; and
 - 11 3. Upon the third violation, deem the individual ineligible for all public
12 assistance programs administered by the cabinet under this chapter for a
13 period of not more than five (5) years.
- 14 (13) (a) Notwithstanding any other provision of Kentucky law, the following shall be
15 disregarded for the purposes of determining an individual's eligibility for a
16 means-tested public assistance program, and the amount of assistance or
17 benefits the individual is eligible to receive under the program:
- 18 1. Any amount in an ABLE account;
 - 19 2. Any contributions to an ABLE account; and
 - 20 3. Any distribution from an ABLE account for qualified disability
21 expenses.
- 22 (b) For purposes of this subsection:
- 23 1. "ABLE account" means an account established within any state having a
24 qualified ABLE program as provided in 26 U.S.C. sec. 529A, as
25 amended;
 - 26 2. "Kentucky law" includes:
 - 27 a. All provisions of the Kentucky Revised Statutes:

- 1 b. Any contract to provide Medicaid managed care established
2 pursuant to this chapter;
- 3 c. Any agreement to operate a Medicaid program established
4 pursuant to this chapter; and
- 5 d. Any administrative regulation promulgated pursuant to this
6 chapter; and
- 7 3. "Qualified disability expenses" means expenses described in 26 U.S.C.
8 sec. 529A of a person who is the beneficiary of an ABLE account.

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

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

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

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

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

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

27 *(b) Contracting with a vendor or other subcontractor for the purpose of*

1 engaging in activities the managed care organization is prohibited from
2 engaging in under paragraph (a) of this subsection;

3 (c) Penalizing a primary care provider for the primary care provider's inability
4 to make contact with a Medicaid enrollee that has been assigned to the
5 primary care provider's roster if the primary care provider has made a
6 good-faith effort, as defined by the Department for Medicaid Services in its
7 contract with a managed care organization, to contact the enrollee;

8 (d) Advertising or otherwise marketing the Medicaid program except to indicate
9 the managed care organization's participation in the Medicaid program;
10 and

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

14 2. As used in this paragraph, "inactive Medicaid provider" means an
15 enrolled Medicaid provider who has submitted fewer than one (1)
16 encounter or claim for payment for Medicaid covered services to a
17 given managed care organization per month for the previous twelve
18 (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
22 receiving notice from any source of the death of a Medicaid enrollee served
23 by the managed care organization;

24 (b) Collaborate with the Department for Medicaid Services to implement and
25 execute a value-based payment model that aligns incentives for enrollees,
26 providers, managed care organizations, and the Commonwealth to improve
27 quality and health care outcomes. The value-based payment model required

1 under this subsection shall include a two percent (2%) withhold from each
2 managed care organization's capitation amount that can be earned back in
3 full or in part by the managed care organization through the achievement
4 of designated value-based measures that 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;

12 (c) Collaborate with the Department for Medicaid Services to implement and
13 execute a performance-based payment model that aligns incentives for
14 enrollees, providers, managed care organizations, and the Commonwealth
15 to improve administration of the Medicaid program and delivery of
16 Medicaid-covered services. The performance-based payment model required
17 under this subsection shall include a two percent (2%) withhold from each
18 managed care organization's capitation amount that can be earned back in
19 full or in part by the managed care organization through the achievement
20 of designated performance-based measures that shall include but not be
21 limited to:

- 22 1. Timely claims processing and payment;
- 23 2. Provider network and network adequacy;
- 24 3. Utilization management;
- 25 4. Program integrity; and
- 26 5. Covered services; and

27 (d) Comply with:

- 1 1. This section and Sections 3, 12, 13, and subsection (2) of Section 6 of
2 this Act;
- 3 2. All terms, conditions, requirements, performance standards, and
4 obligations created under or included in the contract between the
5 managed care organization and the cabinet for the delivery of
6 Medicaid services;
- 7 3. KRS 304.17A-708; and
- 8 4. All sections of Subtitle 17A of KRS Chapter 304 listed in KRS
9 205.522;
- 10 (3) If the Department for Medicaid Services receives mail returned as undeliverable
11 following an attempt to contact a Medicaid beneficiary by first class mail, the
12 department shall notify the beneficiary's managed care organization. If the
13 managed care organization is unable to provide the department with a valid
14 Kentucky address for the beneficiary within fourteen (14) business days, the
15 department shall, to the extent permitted under federal law, disenroll the
16 individual from the Medicaid program pending any appeal that may be required
17 or guaranteed under federal law;
- 18 (4) The Department for Medicaid Services shall, in all instances, exercise its rights
19 under a contract with a Medicaid managed care organization to impose all
20 remedies available to the department under the terms of the contract, at law, or
21 equity if the department determines that the managed care organization or a
22 subcontractor acting on behalf of the managed care organization has:
- 23 (a) Violated any provision of the contract between the department and the
24 managed care organization; or
- 25 (b) Failed to fully comply with any applicable state or federal law or regulation,
26 compliance with which is mandated expressly or implicitly by the contract;
27 and

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

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

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

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

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

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

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

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

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

26 (b) The fund shall consist of all penalties or fines imposed by the cabinet on a
 27 managed care organization for violations of Section 10 of this Act, any

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

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

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

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

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

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

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

24 ➔Section 12. KRS 205.533 is amended to read as follows:

25 (1) [By January 1, 2019,]A managed care organization shall **maintain**[~~establish~~] an
 26 interactive **website**[~~Web site~~], operated by the managed care organization, that
 27 allows providers to file grievances, appeals, and supporting documentation

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

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

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

10 **1. Behavioral health;**

11 **2. Physical health; and**

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

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

15 **1. Internal appeals; and**

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

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

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

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

23 (a) Provide:

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

27 2. A toll-free telephone line for providers to submit requests for

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

1 denied for timely filing if the initial claim was timely submitted;~~and~~

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

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

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

12 b. Failure of the managed care organization to comply with
13 subdivision a. of this subparagraph shall result in:

14 i. A fine or penalty as provided in subsection (6) of this
15 section; or

16 ii. If related to an unresolved appeal, granting the provider's
17 appeal to reimburse and reversal of the managed care
18 organization's reduction or denial of the claim; and

19 3. Ensuring that, following the resolution of an appeal that results in a
20 determination that a monetary amount is owed to a provider, payment
21 is made in full to the provider within thirty (30) days from the date on
22 which the appeal was resolved. Payments required under this
23 subparagraph shall include:

24 a. The monetary amount determined to be owed to the provider plus
25 interest in accordance with KRS 304.17A-730; and

26 b. If applicable, reasonable attorney's fees incurred by the provider
27 to appeal the managed care organization's denial; and

1 (e) With regard to provider audits:

2 1. a. Ensure, except as provided in subdivision b. of this
3 subparagraph, that audit requests are reasonable in regard to the
4 number of providers being audited, the number of records being
5 audited, and the timeframe audit records cover by utilizing a
6 valid sampling methodology to determine which providers may
7 be audited, the number of records that may be audited, and the
8 timeframe covered by records that may be audited.

9 b. The requirement in subdivision a. of this subparagraph that
10 audit decisions be based on a valid sampling methodology shall
11 not apply to cases in which an allegation of fraud, willful
12 misrepresentation, or abuse is made by the managed care
13 organization.

14 c. A managed care organization shall notify the department of any
15 allegations of fraud, willful misrepresentation, or abuse prior to
16 initiating a provider audit;

17 2. Provide written notification to a provider that he or she is being
18 audited. The written notification shall include:

19 a. The date the written notification was sent to the provider;

20 b. An explanation of the purpose of the audit;

21 c. The number of records being audited;

22 d. The timeframe covered by the records being audited;

23 e. The number of calendar days the provider shall be allowed to
24 provide or grant access to the requested records in accordance
25 with subparagraph 3. of this paragraph;

26 f. The managed care organization's or, if the managed care
27 organization has contracted with a third-party entity to conduct

1 the audit, the third-party entity's point of contact for the audit,
2 including the individual's name, telephone number, mailing
3 address, email address, and fax number; and

4 g. Complete written instructions for filing an appeal, including how
5 the appeal shall be submitted by the provider to the managed
6 care organization or, if the managed care organization has
7 contracted with a third-party entity to conduct the audit, the
8 third-party entity;

9 3. Allow at least thirty (30) calendar days for a provider to provide or
10 grant access to the requested records, except that a provider shall be
11 allowed:

12 a. A minimum of sixty (60) calendar days if more than thirty (30)
13 records are being requested or if the timeframe the records cover
14 is more one (1) year; and

15 b. Additional time beyond the minimally required thirty (30) or
16 sixty (60) calendar days if the provider is concurrently subject to
17 audits by more than one (1) managed care organization or
18 provides other justification for the need for additional time;

19 4. Limit the timeframe of records requested as part of an audit to not
20 more than two (2) years from the date on which a claim was submitted
21 for payment, except that a longer timeframe shall be permitted if
22 allowed under federal law or if there is a credible allegation of fraud.
23 If evidence of fraud exists, the managed care organization shall notify
24 the department of the evidence of fraud prior to initiating a provider
25 audit;

26 5. Complete an audit within one hundred eighty (180) calendar days
27 from the date on which the written audit notification required under

- 1 subparagraph 2. of this paragraph was sent to the provider;
- 2 6. Deliver written findings of a completed audit to the provider within
- 3 thirty (30) calendar days of date on which the audit was completed.
- 4 Written audit findings shall:
- 5 a. Include the name, phone number, mailing address, email
- 6 address, and fax number of the managed care organization's or,
- 7 if the managed care organization has contracted with a third-
- 8 party entity to conduct the audit, the third-party entity's point of
- 9 contact responsible for the audit findings;
- 10 b. Provide claims-level detail of the amounts and reasons for each
- 11 claim recovery found to be due; and
- 12 c. Clearly state if no amounts have been found to be due;
- 13 7. a. Exempt, as provided in subparagraph 8. of this paragraph, a
- 14 provider from recoupment of funds if an audit results in the
- 15 identification of any clerical or recordkeeping errors, including
- 16 typographical errors, scrivener's errors, omissions, or computer
- 17 errors, unless the auditing entity provides proof of intent to
- 18 commit fraud or the error results in an actual overpayment to the
- 19 provider.
- 20 b. If an auditing entity discovers or is otherwise in possession of
- 21 proof of intent to commit fraud, the auditing entity shall
- 22 immediately notify the department;
- 23 8. Allow the provider to submit amended claims within thirty (30)
- 24 calendar days of the discovery of a clerical or recordkeeping error in
- 25 lieu of recoupment if the services were otherwise provided in
- 26 accordance with state and federal law;
- 27 9. Not receive payment based on the amount recovered in the audit;

- 1 10. a. Only recoup denied payments or issue a demand for payment
 2 from a provider upon the final disposition of the audit, including
 3 the appeals process as established in KRS 205.646; and
 4 b. Reimburse the provider any recouped payments plus twenty-five
 5 percent (25%) interest on the recouped payments if:
 6 i. The managed care organization recoups payments prior to
 7 the final disposition of the audit, including the appeals
 8 process as established in KRS 205.646; and
 9 ii. The final disposition of the audit, including any appeal
 10 conducted in accordance with KRS 205.646, results in a
 11 finding in favor of the provider;
- 12 11. Base recoupment of claims on the actual overpayment or
 13 underpayment of claims unless the provider agrees to a settlement to
 14 the contrary; and
- 15 12. When feasible, structure the recoupment of claims or demand for
 16 payment in a manner that does not cause a substantial reduction in
 17 cash flow for the provider.

- 18 (2) (a) For the purposes of this subsection:
- 19 1. "Timely" means that an authorization or preauthorization request shall
 20 be approved:
- 21 a. For an expedited authorization request, within twenty-four
 22 (24)~~seventy two (72)~~ hours after receipt of the request. The
 23 timeframe for an expedited authorization request may be extended
 24 by up to fourteen (14) days if:
- 25 i. The enrollee requests an extension; or
- 26 ii. The Medicaid managed care organization justifies to the
 27 department a need for additional information and how the

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

- 1 2. The number of requests for authorization of services and the number of
2 such requests that were approved and denied;
- 3 3. The number of internal appeals and grievances filed by members and by
4 providers and the type of service related to the grievance or appeal, **the**
5 **total dollar amount of all denials being appealed,** the time of
6 resolution, the number of internal appeals and grievances where the
7 initial denial was overturned and the type of service and dollar amount
8 associated with the overturned denials; ~~and~~
- 9 4. **For each internal appeal or grievance not resolved within sixty (60)**
10 **calendar days, the name of the provider who filed the unresolved**
11 **internal appeal or grievance, the dollar amount of the claim that was**
12 **denied if a denial is being appealed, the reason for the delay in**
13 **resolving the internal appeal or grievance, the current status of the**
14 **internal appeal or grievance, and the outcome determination if**
15 **rendered prior to the filing of the report; and**
- 16 5. Any other information required by the department.
- 17 (b) The data required in paragraph (a) of this subsection shall be separately
18 reported by provider category, as prescribed by the department, and shall at a
19 minimum include inpatient acute care hospital services, inpatient psychiatric
20 hospital services, outpatient hospital services, residential behavioral health
21 services, and outpatient behavioral health services.
- 22 (4) On a monthly basis, the department shall transmit to the Department of Insurance a
23 report of each corrective action plan, fine, or sanction assessed against a Medicaid
24 managed care organization for violation of a Medicaid managed care organization's
25 contract relating to prompt payment of claims. The Department of Insurance shall
26 then make a determination of whether the contract violation was also a violation of
27 KRS 304.17A-700 to 304.17A-730.

- 1 (5) By December 15 of each year, the department shall submit to the Legislative
 2 Research Commission for referral to the Interim Joint Committee on Health
 3 Services, the Legislative Oversight and Investigations Committee, and the
 4 Medicaid Oversight and Advisory Board a report containing the following
 5 information for the previous state fiscal year and reported separately for each
 6 managed care organization with whom the department has contracted for the
 7 delivery of Medicaid services:
- 8 (a) The number and dollar value of all claims that were received by the
 9 managed care organization and the number and dollar value of those
 10 claims that were approved for payment, denied, or suspended;
- 11 (b) The number of requests for authorization of services received and the
 12 number of those requests that were approved or denied;
- 13 (c) The number of internal appeals and grievances filed by Medicaid enrollees
 14 and by providers, the types of services to which the internal appeals and
 15 grievances relate, the total dollar amount of denials that were appealed, the
 16 average length of time to resolution, the number of internal appeals and
 17 grievances where the initial denial was overturned, and the types of services
 18 and dollar amount of overturned denials; and
- 19 (d) The number of internal appeals and grievances not resolved within sixty
 20 (60) calendar days, the ten (10) most common reasons given for delays, the
 21 total dollar amount when a denial is being appealed, and the number of
 22 final determinations made in favor of a provider.
- 23 (6) Any Medicaid managed care organization that fails to comply with subsection
 24 (1)(d)2. of this section or KRS 205.522, 205.532 to 205.536, ~~or~~ ~~and~~ 304.17A-515
 25 may be subject to fines, penalties, and sanctions, up to and including termination, as
 26 established under its Medicaid managed care contract with the department.
- 27 (7) The department may promulgate administrative regulations in accordance with

1 *KRS Chapter 13A to implement and enforce this section.*

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

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

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

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

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

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

15 *a. Actuarially sound;*

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

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

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

27 *(c) Require regional brokers to:*

- 1 1. Achieve an annual medical loss ratio of at least ninety percent (90%)
2 on capitation payments;
- 3 2. Provide a remittance to the state of any excess capitation payments for
4 any year in which the regional broker fails to achieve a medical loss
5 ratio of at least ninety percent (90%);
- 6 3. Ensure that all vehicles used to provide Medicaid-covered
7 nonemergency medical transportation services are equipped with a
8 global positioning system device that enables the broker to determine
9 the precise location of the vehicle at all times when the vehicle is being
10 operated to provide nonemergency medical transportation services;
11 and
- 12 4. Collaborate with the Department for Medicaid Services, or another
13 agency in state government or a private entity with which the
14 department has contracted for the administration of a nonemergency
15 medical transportation service program, to implement and execute a
16 performance-based payment model that aligns incentives for Medicaid
17 enrollees, drivers, regional brokers, and the Commonwealth to
18 improve quality, reliability, and cost-effectiveness in the
19 nonemergency medical transportation service program. The
20 performance-based payment model required under this subparagraph
21 shall include a two percent (2%) withhold from each regional broker's
22 capitation amount that can be earned back in full or in part by the
23 regional transportation broker through the achievement of designated
24 performance-based measures which shall:
 - 25 a. Be developed in a manner that reflects the unique circumstances
26 of each region; and
 - 27 b. Include but not be limited to:

- 1 i. Utilization rates;
- 2 ii. The number of nonemergency medical transportation
- 3 service trips completed;
- 4 iii. The number of nonemergency medical transportation
- 5 service trips canceled or rescheduled;
- 6 iv. The number of delayed nonemergency medical
- 7 transportation service trips;
- 8 v. Average trip time;
- 9 vi. Average miles per trip;
- 10 vii. The amount of time required to schedule a nonemergency
- 11 medical transportation service; and
- 12 viii. Rider satisfaction.
- 13 (3) Utilization rates for nonemergency medical transportation services, including
- 14 when calculated by an actuary under subsection (2) of this section, shall consider
- 15 only nonemergency medical transportation service eligible Medicaid enrollees, as
- 16 determined by the Department for Medicaid Services in accordance with
- 17 subsection (2)(c) of Section 5 of this Act, within a given region and shall not be
- 18 based on the total number of Medicaid enrollees.
- 19 (4) (a) A skilled nursing facility or hospital shall be permitted to provide
- 20 nonemergency medical transportation services for residents of the skilled
- 21 nursing facility or patients of the hospital if the transportation service would
- 22 be considered a Medicaid-covered service if provided by a driver contracted
- 23 by a nonemergency medical transportation service regional broker.
- 24 (b) A skilled nursing facility or hospital that provides nonemergency medical
- 25 transportation services under this subsection shall be eligible for
- 26 reimbursement by the locally contracted nonemergency medical
- 27 transportation service regional broker at the same mileage rate as would be

1 paid to a driver contracted by the regional broker for the same service.

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

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

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

20 (a) Utilization rates;

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

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

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

26 (e) Average trip time;

27 (f) Average miles per trip;

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

3 (h) Rider satisfaction; and

4 (i) The performance-based payment model required under subsection (4) of
 5 this section.

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

8 (1) As used in this section and Section 16 of this Act:

9 (a) "Department":

10 1. Means the Department for Medicaid Services; and

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

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

18 (c) "Waiver program application" means any waiver program application,
 19 including a waiver waitlist application or application to begin receiving
 20 waiver program services.

21 (2) (a) The department shall require any individual applying for waiver program
 22 services, including any individuals applying for or requesting placement on
 23 a waiver waitlist, to submit a completed waiver program application that
 24 includes a physician's recommendation for waiver program services and
 25 physician attestation to the primary diagnosis for which the individual is
 26 seeking waiver program services.

27 (b) Except as provided in paragraph (c) of this subsection, the department shall

1 not place any individual on a waiver waitlist or approve any individual to
2 receive waiver program services if the individual has not completed and
3 submitted a waiver program application that includes a physician's
4 recommendation for waiver program services and physician attestation to
5 the primary diagnosis for which the individual is seeking waiver program
6 services.

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

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

20 (a) Be nationally recognized;

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

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

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

- 1 (5) A waiver program participant's case manager shall serve as the sole liaison to the
2 department for ongoing patient follow-up care, care coordination, care plan
3 updates, and prior authorization updates.
- 4 (6) The department shall undertake efforts to encourage waiver service providers to
5 develop innovative programs that increase the quality and value of care while
6 reducing costs of the waiver programs.
- 7 (7) (a) Except as provided in paragraphs (b) and (c) of this subsection and if
8 approved by the federal Centers for Medicare and Medicaid Services, in
9 order to be eligible for enrollment in a waiver program an individual shall
10 be a citizen of the United States and have been a resident of the
11 Commonwealth for at least one (1) year prior to enrollment.
- 12 (b) Notwithstanding paragraph (a) of this subsection, an individual who has
13 been a resident of the Commonwealth for less than one (1) year may be
14 enrolled in a waiver program for which there is no waitlist.
- 15 (c) This subsection shall not apply to:
- 16 1. Individuals enrolled in a waiver program prior to the effective date of
17 this Act; or
- 18 2. Members of the United States Armed Forces, their spouses or
19 dependents, or veterans.
- 20 (8) The cabinet shall reserve capacity in each waiver program to ensure availability
21 of waiver slots for individuals determined to have an emergency need status and
22 shall develop waitlist management policies for individuals seeking emergency
23 placement in a waiver program, including but not limited to, by January 1, 2027,
24 for each waiver program, development of waiver-specific emergency need
25 allocation criteria for any waiver program for which such criteria do not
26 currently exist.
- 27 (9) (a) For the purposes of identifying and eliminating waste, fraud, and abuse in

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

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

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

27 ➔SECTION 16. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO

1 READ AS FOLLOWS:

2 (1) No later than January 1, 2027, the department shall:

3 (a) Develop and implement a tiered priority system for assigning a priority level
4 for each waiver program applicant who meets waiver eligibility criteria but
5 for whom a waiver program slot is not immediately available. The tiered
6 priority system shall be based on a standardized assessment of functional
7 needs and risk factors that include but are not limited to:

8 1. Risk of institutionalization in the absence of waiver services;

9 2. Severity of physical or cognitive functional impairment;

10 3. Current unmet needs for activities of daily living or medically
11 necessary supports;

12 4. Health and safety risks to the applicant and others; and

13 5. Any other criteria the department determines may be appropriate to
14 equitably prioritize access to waiver services; and

15 (b) Develop or adopt a standardized assessment tool to determine an applicant's
16 priority level. The assessment tool shall be:

17 1. Evidence-based and aligned with person-centered functional
18 assessment practices;

19 2. Applied consistently across all waiver programs for which there is a
20 waitlist; and

21 3. Administered at the time of the initial application for waiver program.

22 (2) Beginning January 1, 2027, access to waiver program services and the allocation
23 of waiver slots within any waiver program for which there is a waitlist shall be
24 based on an applicant's assigned priority level.

25 (3) (a) The department shall promulgate administrative regulations in accordance
26 with KRS Chapter 13A to implement this section, including administrative
27 regulations to establish:

1 1. The priority tier definitions and scoring criteria;

2 2. Applicant assessment and annual reassessment procedures; and

3 3. An appeals process for priority level determinations.

4 (b) Administrative regulations promulgated under this subsection shall be
5 consistent with federal Medicaid law and federal waiver program
6 requirements.

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

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

10 (a) Effective management of Medicaid-covered dental services is essential for
11 the overall health of Medicaid beneficiaries and that specialized
12 administration of dental services may improve programmatic efficiency,
13 oral health, and overall health outcomes in the Commonwealth; and

14 (b) It is the intent of the General Assembly to authorize the Department for
15 Medicaid Services to administer Medicaid-covered dental services under an
16 administrative services organization delivery model beginning January 1,
17 2028, and for the administrative service organization contracted in
18 accordance with this section to perform administrative functions necessary
19 to manage or process claims, prior authorization requests, coordination of
20 care, network adequacy, and customer service related to Medicaid-covered
21 dental services.

22 (2) As used in this section:

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

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

2 (3) The department shall:

3 (a) No later than July 1, 2028, employ a full-time Medicaid dental director who
4 shall:

5 1. Be licensed under KRS Chapter 313;

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

7 3. Be responsible for overseeing the administration of Medicaid-covered
8 dental services;

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

13 (c) In accordance with KRS Chapter 45A and subsection (5) of this section,
14 select and contract with a third-party ASO to administer Medicaid-covered
15 dental services. The contract entered into under this paragraph shall have
16 an effective date of no later than January 1, 2029;

17 (d) Promulgate administrative regulations in accordance with KRS Chapter
18 13A to implement this section;

19 (e) No later than January 1, 2029:

20 1. Transition all Medicaid beneficiaries from Medicaid managed care
21 organization coverage into ASO coverage for the administration of all
22 Medicaid-covered dental services; and

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

24 a. Include the following members:

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

27 ii. The members of Technical Advisory Committee on Dental

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

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

1 Services, and the Medicaid Oversight and Advisory Board by August 1,
2 2029, and August 1 of each year thereafter.

3 ➔SECTION 18. A NEW SECTION OF KRS 7A.270 TO 7A.290 IS CREATED
4 TO READ AS FOLLOWS:

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

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

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

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

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

27 (e) Existing policies and procedures for the acquisition of current and timely

1 data, evidence, records, and information by the General Assembly from the
2 cabinet and its various departments and divisions is unnecessarily
3 bureaucratic and burdensome in nature and frequently results in untimely
4 delays that hinder the General Assembly's ability to discharge its legislative
5 duties; and

6 (f) Providing the General Assembly with continuous and ongoing access to
7 data, evidence, records, and information pertaining to the Medicaid
8 program and the administration thereof is critical to ensuring that the
9 General Assembly is able to conduct the thorough and systematic
10 evaluations that are a necessary precursor to the body's effective and
11 meaningful discharge of its oversight, policy-making, and appropriation
12 duties.

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

19 (b) No later than thirty (30) calendar days after the effective date of this Act,
20 the director of the Commission shall provide the cabinet with a list of
21 databases, datasets, electronic records, and files determined by the director
22 to be necessary for the meaningful and effective discharge of legislative
23 duties, including oversight, policy making, and the appropriation of funds to
24 provide for the administration of the Medicaid program by the General
25 Assembly.

26 (c) No later than July 1, 2026, the cabinet shall provide the General Assembly
27 with continuous and ongoing access to all databases, datasets, electronic

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

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

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

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

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

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

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

1 any aspect thereof, including but not limited to any vendor with which the
 2 Commission may contract pursuant to Section 22 of this Act;

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

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

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

18 (6) In addition to the data-sharing requirements established in subsections (2), (3),
 19 (4), and (5) of this section, the cabinet shall provide the Commission with a copy
 20 of any reports or data that may be submitted to the cabinet by any vendor or entity
 21 with which the cabinet has contracted for administration, examination, study, or
 22 review of any aspect of the Medicaid program.

23 ➔SECTION 19. A NEW SECTION OF KRS 7A.270 TO 7A.290 IS CREATED
 24 TO READ AS FOLLOWS:

25 (1) In order to facilitate the board's ongoing efforts to continuously improve health
 26 outcomes in a cost-efficient and effective manner, the Commission, the University
 27 of Kentucky, and the University of Louisville shall enter into a partnership to

1 design and develop a web-based healthcare transparency dashboard that tracks,
 2 at a minimum:

3 (a) Leading health indicators;

4 (b) Performance indicators for Medicaid managed care organizations;

5 (c) Performance indicators for Medicaid-participating providers; and

6 (d) Performance indicators for the department.

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

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

10 (b) Cancer screenings;

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

12 (d) Postpartum care;

13 (e) Diabetes care and management; and

14 (f) Hypertension care and management.

15 (3) The healthcare transparency dashboard shall be:

16 (a) Overseen by a subcommittee of the board established in accordance
 17 subsection (4) of Section 20 of this Act; and

18 (b) Maintained and operated by the Commission.

19 ➔Section 20. KRS 7A.283 is amended to read as follows:

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

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

27 (a) The cabinet;

- 1 (b) The department;
- 2 (c) Any other state agency;
- 3 (d) Any Medicaid managed care organization with whom the department has
4 contracted for the delivery of Medicaid services;
- 5 (e) The state pharmacy benefit manager contracted by the department pursuant to
6 KRS 205.5512; and
- 7 (f) Any other entity contracted by a state agency to administer or assist in
8 administering any aspect of the Medicaid program or the delivery of Medicaid
9 benefits or services;
- 10 (2) Establish a uniform format for reports and data submitted to the board and the
11 frequency, which may be monthly, quarterly, semiannually, annually, or biannually,
12 and the due date for the reports and data;
- 13 (3) Conduct public hearings in furtherance of its general duties, at which it may request
14 the appearance of officials of any state agency and solicit the testimony of
15 interested groups and the general public;
- 16 (4) Establish any advisory committees or subcommittees of the board that the board
17 deems necessary to carry out its duties **and upon approval of the Commission:**
- 18 **(a) Include in the membership of an advisory committee or subcommittee**
19 **individuals who are not members of the board; and**
- 20 **(b) Appoint as co-chairs of an advisory committee or subcommittee individuals**
21 **who are not members of the General Assembly;**
- 22 (5) Recommend that the Auditor of Public Accounts perform a financial or special
23 audit of the Medicaid program or any aspect thereof; and
- 24 (6) Subject to selection and approval by the ~~[Legislative Research]~~ Commission, utilize
25 the services of consultants, analysts, actuaries, legal counsel, and auditors to render
26 professional, managerial, and technical assistance, as needed.

27 ➔SECTION 21. A NEW SECTION OF KRS CHAPTER 43 IS CREATED TO

1 READ AS FOLLOWS:

2 (1) Beginning July 1, 2026, and at least once every five (5) years thereafter, the
3 Auditor shall initiate and conduct a full and comprehensive examination of the
4 state's Medicaid program and the Kentucky Children's Health Insurance
5 Program. The scope of the comprehensive examination required under this
6 section shall cover the previous five (5) state fiscal years and include:

7 (a) A financial examination of the programs' books, accounts, and papers;

8 (b) A compliance examination to ensure that the programs are in compliance
9 with all state and federal laws and regulations governing the Medicaid
10 program and the Kentucky Children's Health Insurance Program; and

11 (c) A performance examination to ensure that the Cabinet for Health and
12 Family Services and its various departments and divisions are administering
13 the programs in an efficient and effective manner.

14 (2) In addition to the requirements established in subsection (1) of this section, for
15 the first full and complete examination conducted in accordance with subsection
16 (1) of this section, the Auditor shall prioritize examination and review of the
17 following:

18 (a) All federal Centers for Medicare and Medicaid Services approved waiver-
19 related documents, including but not limited to all 1915(c) and 1115 waiver-
20 related documents, submitted by the Cabinet for Health and Family
21 Services, or any department or division thereof;

22 (b) Policies and procedures developed and implemented by the Cabinet for
23 Health and Family Services, or any department or division thereof, for
24 1915(c) waiver waitlist management efforts;

25 (c) The accuracy of all 1915(c) waiver waitlist applications, including, when
26 possible, determining whether individuals on each of the 1915(c) waiver
27 waitlists meet applicable eligibility requirements for placement on a 1915(c)

1 waiver waitlist;

2 (d) Health care service utilization trends, including Medicaid state plan covered
3 services, among individuals on each of the 1915(c) waiver waitlists
4 including, when possible, determining whether the health care utilization
5 trends of individuals on a 1915(c) waiver waitlist justify placement on a
6 waitlist;

7 (e) The accuracy, based on federal Centers for Medicare and Medicaid Services
8 approved criteria, of eligibility determinations for all individuals currently
9 receiving 1915(c) waiver services;

10 (f) All 1915(c) waiver assessments and services for the purpose of identifying
11 programmatically inefficiencies and duplications;

12 (g) All 1915(c) waiver-related contracts entered into by the Cabinet for Health
13 and Family Services, or any department or division thereof, for the purpose
14 of identifying programmatically inefficiencies and duplications and assessing
15 the sufficiency of oversight and enforcement;

16 (h) The patient directed services program to assess the adequacy of fraud,
17 waste, and abuse controls associated with the program; and

18 (i) Staffing, including both staff employed directly by the Cabinet for Health
19 and Family Services and contract staff, associated with the 1915(c) waiver
20 programs for the purpose of:

21 1. Identifying staffing inefficiencies or duplications;

22 2. Ensuring staffing compliance with approved waiver documents, third-
23 party vendor contracts, and human resources policies; and

24 3. Assessing how current staffing decisions align with the strategic goals
25 and objectives of the 1915(c) waiver programs.

26 (3) In each year in which the Auditor does not conduct a full and comprehensive
27 examination as required under subsection (1) of this section, the Auditor shall

1 conduct a review of the state's Medicaid program and the Kentucky Children's
2 Health Insurance Program for the purpose of assessing the Cabinet for Health
3 and Family Services' progress in addressing any issues or recommendations that
4 were identified in the most recent report prepared in accordance with subsection
5 (4)(b) of this section.

6 (4) The Auditor shall:

7 (a) Submit an initial preliminary report of the results of each examination
8 conducted in accordance with subsection (1) of this section to the
9 Legislative Research Commission for referral to the Interim Joint
10 Committees on Appropriations and Revenue, Families and Children, and
11 Health Services and the Medicaid Oversight and Advisory Board no later
12 than December 1 of the year in which the examination is initiated;

13 (b) Immediately upon completion of each examination required under
14 subsection (1) of this section, prepare a report of his or her findings noting
15 any:

16 1. Instance in which the programs are not in compliance with relevant
17 state or federal laws or regulations;

18 2. Duplication of service or any other inefficiencies;

19 3. Inaccuracies in the programs' financial statements or documents;

20 4. Waste, fraud, or abuse; and

21 5. Recommendations for improving the operation and administration of
22 the programs;

23 (c) By September 1, 2027, and at least every five (5) years thereafter, provide
24 the Legislative Research Commission with a copy of the report prepared
25 pursuant to paragraph (b) of this subsection for referral to the Interim Joint
26 Committees on Appropriations and Revenue, Families and Children, and
27 Health Services and the Medicaid Oversight and Advisory Board; and

1 (d) Report the findings of any review conducted pursuant to subsection (2) or
2 (3) of this section to the Legislative Research Commission no later than
3 November 1 of the year in which the review is completed. A report submitted
4 in accordance with this paragraph shall be referred to the Interim Joint
5 Committees on Appropriations and Revenue, Families and Children, and
6 Health Services and the Medicaid Oversight and Advisory Board.

7 (5) The cost of an examination conducted pursuant to subsection (1) of this section
8 shall be borne by the Department for Medicaid Services, and the department shall
9 be required to take all necessary steps to access and drawdown any federal funds
10 as may be available to support state efforts to ensure program integrity or audit
11 activities.

12 ➔Section 22. KRS 7A.286 is amended to read as follows:

13 (1) The board, consistent with its purpose as established in KRS 7A.273, shall:

14 (a) On an ongoing basis, conduct an impartial review of all state laws and
15 regulations governing the Medicaid program and recommend to the General
16 Assembly any changes it finds desirable with respect to program
17 administration, including delivery system models, program financing, benefits
18 and coverage policies, reimbursement rates, payment methodologies, provider
19 participation, or any other aspect of the program;

20 (b) On an ongoing basis, review any change or proposed change in federal laws
21 and regulations governing the Medicaid program and report to the Legislative
22 Research Commission on the probable costs, possible budgetary implications,
23 potential effect on healthcare outcomes, and the overall desirability of any
24 change or proposed change in federal laws or regulations governing the
25 Medicaid program;

26 (c) At the request of the Speaker of the House of Representatives or the President
27 of the Senate, evaluate proposed changes to state laws affecting the Medicaid

- 1 program and report to the Speaker or the President on the probable costs,
2 possible budgetary implications, potential effect on healthcare outcomes, and
3 overall desirability as a matter of public policy;
- 4 (d) At the request of the ~~{Legislative Research}~~ Commission, research issues
5 related to the Medicaid program;
- 6 (e) Beginning in 2026 and at least once every five (5) years thereafter, cause a
7 review to be made of the administrative expenses and operational cost of the
8 Medicaid program. The review shall include but not be limited to evaluating
9 the level and growth of administrative costs, the potential for legislative
10 changes to reduce administrative costs, and administrative changes the
11 department may make to reduce administrative costs or staffing needs. At the
12 discretion of the ~~{Legislative Research}~~ Commission, the review may be
13 conducted by a consultant retained by the board;
- 14 (f) Beginning in 2027 and at least once every five (5) years thereafter, cause a
15 program evaluation to be conducted of the Medicaid program. In any instance
16 in which a program evaluation indicates inadequate operating or
17 administrative system controls or procedures, inaccuracies, inefficiencies,
18 waste, extravagance, unauthorized or unintended activities, or other
19 deficiencies, the board shall report its findings to the ~~{Legislative Research}~~
20 ~~}~~ Commission. The program evaluation shall be performed by a consultant
21 retained by the board;
- 22 (g) Beginning in 2028 and at least once every five (5) years thereafter, cause an
23 actuarial analysis to be performed of the Medicaid program, to evaluate the
24 sufficiency and appropriateness of Medicaid reimbursement rates established
25 by the department and those paid by any managed care organization
26 contracted by the department for the delivery of Medicaid services. The
27 actuarial analysis shall be performed by an actuary retained by the board;

- 1 (h) Beginning in 2029 and at least once every five (5) years thereafter, cause the
2 overall health of the Medicaid population to be assessed. The assessment shall
3 include but not be limited to a review of health outcomes, healthcare
4 disparities among program beneficiaries and as compared to the general
5 population, and the effect of the overall health of the Medicaid population on
6 program expenses. The assessment shall be performed by a consultant
7 retained by the board; and
- 8 (i) Beginning in 2026 and annually thereafter, publish a report covering the
9 board's evaluations and recommendations with respect to the Medicaid
10 program. The report shall be submitted to the ~~Legislative Research~~
11 ~~Commission~~ no later than December 1 of each year, and shall include at a
12 minimum a summary of the board's current evaluation of the program and any
13 legislative recommendations made by the board.
- 14 (2) The board, consistent with its purpose as established in KRS 7A.273, may:
- 15 (a) Review all new or amended administrative regulations related to the Medicaid
16 program and provide comments to the Administrative Regulation Review
17 Subcommittee established in KRS 13A.020;
- 18 (b) Make recommendations to the General Assembly, the Governor, the secretary
19 of the cabinet, and the commissioner of the department regarding program
20 administration, including benefits and coverage policies, access to services
21 and provider network adequacy, healthcare outcomes and disparities,
22 reimbursement rates, payment methodologies, delivery system models,
23 funding, and administrative regulations. Recommendations made pursuant to
24 this section shall be nonbinding and shall not have the force of law; and
- 25 (c) On or before December 1 of each calendar year, adopt an annual research
26 agenda. The annual research agenda may include studies, research, and
27 investigations considered by the board to be significant. Board staff shall

1 prepare a list of study and research topics related to the Medicaid program for
 2 consideration by the board in the adoption of the annual research agenda. An
 3 annual research agenda adopted by the board may be amended by the
 4 ~~Legislative Research~~ Commission to include any studies or reports
 5 mandated by the General Assembly during the next succeeding regular
 6 session.

7 (3) At the discretion of the ~~Legislative Research~~ Commission:

8 **(a) An examination of the Medicaid program conducted by the Auditor of**
 9 **Public Accounts under Section 21 of this Act may constitute fulfillment of**
 10 **the board's duties established in subsection (1)(e) and (f) of this section;**
 11 **and**

12 **(b)** Studies and research projects included in an annual research agenda adopted
 13 by the board pursuant to subsection (2)(c) of this section may be conducted by
 14 outside consultants, analysts, or researchers to ensure the timely completion of
 15 the research agenda.

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

18 **(1) Legislation, including amendments and committee substitutes, that makes or**
 19 **directs a change to the Medicaid program, including but not limited to any**
 20 **change to benefits, eligibility, reimbursement rates, or administration of the**
 21 **program, shall not be reported from a legislative committee of either chamber of**
 22 **the General Assembly for consideration by the full membership of that chamber**
 23 **unless the legislation is accompanied by a Medicaid impact statement.**

24 **(2) (a) Any legislation, including amendments and committee substitutes, that**
 25 **makes or directs a change to the Medicaid program shall be identified by**
 26 **the staff of, and on a form specified by, the Legislative Research**
 27 **Commission.**

1 **(b) For legislation identified as having a Medicaid impact, staff of the**
2 **Legislative Research Commission shall notify the sponsor of the legislation**
3 **that a Medicaid impact statement is required.**

4 **(3) The following individuals may request a Medicaid impact statement be prepared**
5 **for legislation that is subject to this section:**

6 **(a) For any introduced legislation or filed amendment:**

7 **1. The sponsor of the legislation or amendment;**

8 **2. The President of the Senate, if the Senate is in possession of the**
9 **legislation;**

10 **3. The Speaker of the House of Representatives, if the House of**
11 **Representatives is in possession of the legislation;**

12 **4. The chair of a standing committee to which the legislation has been**
13 **referred; or**

14 **5. The co-chairs of the Medicaid Oversight and Advisory Board**
15 **established in KRS 7A.273; and**

16 **(b) For any legislation, amendment, or committee substitute that has not been**
17 **introduced or filed, the sponsor of the legislation, amendment, or committee**
18 **substitute.**

19 **(4) A Medicaid impact statement required under this section shall:**

20 **(a) Show the likely fiscal and economic impact of the legislation over a two (2),**
21 **five (5), and ten (10) year period, including an analysis of any potential**
22 **increase or decrease in:**

23 **1. Revenue, including but not limited to any revenues generated by**
24 **provider taxes, directed payment assessments, pharmaceutical rebates,**
25 **or federal medical assistance or federal Medicaid matching funds;**

26 **2. Expenditures, including:**

27 **a. Expenditures of state general fund moneys, restricted funds, and**

- 1 *federal medical assistance or federal Medicaid matching funds;*
 2 *and*
 3 *b. Any potential cost savings, including but not limited to any cost*
 4 *savings that may result from changes in utilization rates,*
 5 *administrative efficiencies, or improved health of the Medicaid*
 6 *population;*
 7 *3. a. Capitation rates paid to Medicaid managed care organizations*
 8 *contracted by the Department for Medicaid Services; and*
 9 *b. Reimbursement rates for Medicaid-covered services delivered on*
 10 *a fee-for-service basis; and*
 11 *4. Beneficiary enrollment in the Medicaid program including, if*
 12 *applicable, any 1915(c) home and community-based waiver program*
 13 *administered by the Department for Medicaid Services;*
 14 *(b) Be produced by an economic consulting firm retained by the Legislative*
 15 *Research Commission;*
 16 *(c) Be provided in a uniform format established by the Legislative Research*
 17 *Commission; and*
 18 *(d) Include a certification that the information contained in the impact*
 19 *statement is complete and accurate.*
 20 *(5) The economic consulting firm retained by the Legislative Research Commission*
 21 *for Medicaid impact statements shall:*
 22 *(a) Have significant experience in analyzing the fiscal and economic impact of*
 23 *Medicaid-related program changes; and*
 24 *(b) Have the capacity to complete requested Medicaid impact statements within*
 25 *seven (7) business days.*

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

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

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

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

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

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

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

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

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

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

25 Notwithstanding any provision of law to the contrary, the Kentucky Medicaid program,
 26 including the Department for Medicaid Services and any managed care organization
 27 with which the department contracts for the delivery of Medicaid services, shall not

1 *provide coverage for prescription drugs when prescribed primarily for weight loss or*
2 *weight management purposes.*

3 ➔Section 27. The following KRS sections are repealed:

4 205.515 Medicaid program delivery system.

5 311A.172 Provision of nonemergency medical transportation services to a resident by a
6 skilled nursing facility or hospital -- Conditions.

7 ➔Section 28. There is hereby appropriated General Fund moneys from the
8 Budget Reserve Trust Fund Account established by KRS 48.705 in the amount of
9 \$500,000 in fiscal year 2025-2026 to the Auditor of Public Accounts budget unit to fulfill
10 staffing and technology needs related to Section 21 of this Act. Notwithstanding KRS
11 45.229, these funds shall not lapse and shall carry forward.

12 ➔Section 29. (1) The Medicaid Oversight and Advisory Board established in
13 KRS 7A.273 is hereby directed to establish a Dental Services Transition Subcommittee
14 by July 1, 2027, to oversee the implementation of Section 17 of this Act and the
15 transitioning of Medicaid-covered dental service from a managed care delivery model to
16 an administrative services organization delivery model.

17 (2) The Dental Services Transition Subcommittee of the Medicaid Oversight and
18 Advisory Board shall consist of the following members:

19 (a) The Medicaid dental director employed pursuant to subsection (3)(a) of
20 Section 17 of this Act;

21 (b) One additional representative from the Department for Medicaid Services
22 appointed by the secretary of the Cabinet for Health and Family Services;

23 (c) The members of the Technical Advisory Committee on Dental Care
24 established in KRS 205.590;

25 (d) The dean of the University of Pikeville College of Dental Medicine or his or
26 her designee;

27 (e) The dean of the University of Kentucky College of Dentistry or his or her

1 designee;

2 (f) The dean of the University of Louisville School of Dentistry or his or her
3 designee; and

4 (g) Any member of the Medicaid Oversight and Advisory Board who is a
5 Medicaid-participating dental provider.

6 (3) The Dental Services Transition Subcommittee of the Medicaid Oversight and
7 Advisory Board shall:

8 (a) Meet at least monthly unless the chair or co-chairs of the subcommittee
9 determine otherwise;

10 (b) At its first meeting, elect from its membership one member to serve as chair
11 of the subcommittee;

12 (c) Provide legislative oversight, guidance, and recommendations for:

13 1. The transitioning of Medicaid-covered dental service from a managed care
14 delivery model to an administrative services organization delivery model as required
15 under Section 17 of this Act; and

16 2. Best practice for claims management, quality assurance, coordination of care,
17 network adequacy, accessibility, and customer service protocols; and

18 (d) Be dissolved on December 1, 2029.

19 ➔Section 30. If the Cabinet for Health and Family Services or the Department for
20 Medicaid Services determines that a state plan amendment, waiver, or any other form of
21 authorization or approval from any federal agency to implement Sections 1, 2, 3, 4, 5, 6,
22 7, 8, 9, 10, 11, 13, 14, 15, 16, or 17 of this Act is necessary to prevent the loss of federal
23 funds or to comply with federal law, the cabinet or department:

24 (1) Shall, within 90 days after the effective date of this section, request the
25 necessary federal authorization or approval to implement Sections 1, 2, 3, 4, 5, 6, 7, 8, 9,
26 10, 11, 13, 14, 15, 16, and 17 of this Act; and

27 (2) May only delay implementation of the provisions of Sections 1, 2, 3, 4, 5, 6,

1 7, 8, 9, 10, 11, 13, 14, 15, 16, and 17 of this Act for which federal authorization or
2 approval was deemed necessary until the federal authorization or approval is granted.

3 →Section 31. Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, and 30 of
4 this Act shall constitute the specific authorization required under KRS 205.5372(1).

5 →Section 32. The Medicaid Oversight and Advisory Board, established in KRS
6 7A.273, is hereby directed to evaluate the Medicaid nonemergency medical
7 transportation, or NEMT, program during the 2026 Legislative Interim. As part of the
8 evaluation directed by this section the board shall:

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

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

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

16 (b) The regional broker system; and

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

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

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

22 (5) Identify strategies to:

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

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

25 (c) Improve customer satisfaction; and

26 (d) Enhance administrative efficiencies; and

27 (6) Submit a report of the board's findings and recommendations related to the

1 Medicaid NEMT program to the Legislative Research Commission not later than
2 December 31, 2026.

3 ➔Section 33. Provisions of Section 32 of this Act to the contrary notwithstanding,
4 the Legislative Research Commission shall have the authority to alternatively assign the
5 issues identified therein to an interim joint committee or subcommittee thereof, and to
6 designate a study completion date.

7 ➔Section 34. Sections 32 and 33 of this Act shall have the same legal status as a
8 House Concurrent Resolution.

9 ➔Section 35. Whereas recently enacted federal changes to the Medicaid program
10 and significant increases in the Commonwealth's Medicaid budget over the last decade
11 create an urgent need to bolster legislative oversight of the Medicaid program, take
12 immediate steps to comply with new federal requirements, and ensure that Medicaid
13 expenditures support the healthcare needs of only those individuals the program is
14 intended to serve, an emergency is declared to exist, and this Act takes effect upon its
15 passage and approval by the Governor or upon its otherwise becoming a law.