

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) months during the period***
22 ***of time since the individual's most recent eligibility determination or***
23 ***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 subsection (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) (a) Except as provided in paragraph (b) of this subsection and subsections (3)

11 and (5) of this section, beginning October 1, 2028, for care or an item or

12 service furnished to a Medicaid enrolled individual described in subsection

13 (2) of this section, the cost-sharing requirement established under this

14 subsection shall be in the form of a copayment requirement equal to five

15 dollars (\$5).

16 (b) The cost-sharing requirements established under this subsection for any

17 prescription drugs shall be in the form of a copayment requirement equal to

18 one dollar (\$1).

19 (5) The total aggregate amount of cost sharing imposed under this section for all

20 individuals in a family shall not exceed five percent (5%) of the family's income

21 on a monthly or quarterly basis, as determined by the secretary.

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

23 (1) As used in this section:

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

26 (b) "In-home program" means a program offered by a health care facility or
27 health care professional for the treatment of substance use disorder which the

1 insured accesses through telehealth or digital health service;

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

- 7 1. Clinical maternal, child, and feeding history and assessment related to
8 breastfeeding and human lactation through the systematic collection of
9 subjective and objective information;
- 10 2. Analysis of data;
- 11 3. Development of a lactation management and child feeding plan with
12 demonstration and instruction to parents;
- 13 4. Provision of lactation and feeding education;
- 14 5. The recommendation and use of assistive devices;
- 15 6. Communication to the primary health care practitioner or practitioners
16 and referral to other health care practitioners, as needed;
- 17 7. Appropriate follow-up with evaluation of outcomes; and
- 18 8. Documentation of the encounter in a patient record;

19 (d) "Qualified clinical lactation care practitioner" means a licensed health care
20 practitioner wherein lactation consultation is within their legal scope of
21 practice; and

22 (e) "Telehealth" or "digital health" has the same meaning as in KRS 211.332.

23 (2) The Department for Medicaid Services and any managed care organization with
24 which the department contracts for the delivery of Medicaid services shall provide
25 coverage:

26 (a) For lactation consultation;

27 (b) For breastfeeding equipment;

- 1 (c) To pregnant and postpartum women for an in-home program; and
- 2 (d) For telehealth or digital health services that are related to maternity care
- 3 associated with pregnancy, childbirth, and postpartum care.
- 4 (3) The coverage required by this section shall:
- 5 (a) Not be subject to:
- 6 1. Any cost-sharing requirements, including but not limited to copayments,
- 7 *unless otherwise required under federal law*; or
- 8 2. Utilization management requirements, including but not limited to prior
- 9 authorization, prescription, or referral, except as permitted in paragraph
- 10 (d) of this subsection;
- 11 (b) Be provided in conjunction with each birth for the duration of breastfeeding,
- 12 as defined by the beneficiary;
- 13 (c) For lactation consultation, include:
- 14 1. In-person, one-on-one consultation, including home visits, regardless of
- 15 location of service provision;
- 16 2. The delivery of consultation via telehealth, as defined in KRS 205.510,
- 17 if the beneficiary requests telehealth consultation in lieu of in-person,
- 18 one-on-one consultation; or
- 19 3. Group consultation, if the beneficiary requests group consultation in lieu
- 20 of in-person, one-on-one consultation; and
- 21 (d) For breastfeeding equipment, include:
- 22 1. Purchase of a single-user, double electric breast pump, or a manual
- 23 pump in lieu of a double electric breast pump, if requested by the
- 24 beneficiary;
- 25 2. Rental of a multi-user breast pump on the recommendation of a licensed
- 26 health care provider; and
- 27 3. Two (2) breast pump kits as well as appropriately sized breast pump

1 flanges and other lactation accessories recommended by a health care
2 provider.

3 (4) (a) The breastfeeding equipment described in subsection (3)(d) of this section
4 shall be furnished within forty-eight (48) hours of notification of need, if
5 requested after the birth of the child, or by the later of two (2) weeks before
6 the beneficiary's expected due date or seventy-two (72) hours after
7 notification of need, if requested prior to the birth of the child.

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

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

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

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

24 (a) Counseling requirements for medication;

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

27 (c) Copayments or other out-of-pocket cost sharing, including deductibles, unless

1 *otherwise required under federal law.*

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

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

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

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

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

18 *(1) Beginning January 1, 2027, the cabinet shall, in accordance with 42 U.S.C. sec.*
19 *1396a(e)(14)(L), conduct Medicaid eligibility redeterminations once every six (6)*
20 *months for individuals who are:*

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

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

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

26 *(a) Access and review information from all available federal and state data*
27 *systems that may contain information related to eligibility for enrollment or*

1 continued enrollment in the Medicaid program, including but not limited to:

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

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

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

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

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

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

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

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

24 (1) The cabinet shall:

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

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

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

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

11 2. Of the process for submitting proof of current residency to the cabinet
12 and the documents required to be submitted to validate current
13 residency in the Commonwealth; and

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

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

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

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

27 a. That they must submit proof of current residency in the

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

1 organization, the managed care organization's parent company, or
 2 any subsidiary of the managed care organization or its parent
 3 company in another state, regardless of the type of coverage provided
 4 in the other state;

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

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

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

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

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

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

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

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

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

- 1 (6) On at least an annual basis, each enrollment or benefit tracking agency
2 associated with the Medicaid program shall receive and review information from
3 the Department of Revenue concerning individuals enrolled in the Medicaid
4 program that may indicate a change in circumstances that would affect eligibility
5 for enrollment in the Medicaid program, including but not limited to changes in
6 adjusted gross income or family composition.
- 7 (7) On at least a monthly basis, each enrollment or benefit tracking agency
8 associated with the Medicaid program shall receive and review information from
9 the Department of Corrections concerning 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 (8) At a regularly scheduled interval, each enrollment or benefit tracking agency
13 associated with the Medicaid program shall receive and review information
14 related to child support payments received by individuals enrolled in the Medicaid
15 program that may indicate a change in circumstances that would affect eligibility
16 for enrollment in the Medicaid program.
- 17 (9) On at least a quarterly basis, each enrollment and benefit tracking agency
18 associated with the Medicaid program shall review information from the National
19 Change of Address database, or NCOALink, concerning individuals enrolled in
20 the Medicaid program that may indicate a change in circumstances that would
21 affect eligibility for enrollment in the Medicaid program.
- 22 (10) The Department for Medicaid Services shall, as permitted under federal law:
23 (a) Enter into a data exchange agreement with the Social Security
24 Administration to receive the full file of death information on at least a
25 quarterly basis; and
26 (b) Upon receipt of the full file of death information and any update to the file,
27 disenroll from the Medicaid program any individual whose death is reported

1 *in the full file of death information.*

2 ~~(11)~~~~(5)~~ Notwithstanding any other provision of law to the contrary:

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

17 ~~(12)~~~~(6)~~ *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~~ may contract in accordance with KRS Chapter 45A with one (1) or more
 20 independent vendors to provide additional data or information that may indicate a
 21 change in circumstances that *would*~~may~~ affect eligibility.

22 ~~(13)~~~~(7)~~ *The cabinet and* each enrollment or benefit tracking agency associated with
 23 the Medicaid program or the Supplemental Nutrition Assistance Program ~~of the~~
 24 ~~cabinet~~ shall explore joining any multistate cooperative to identify individuals who
 25 are also enrolled in public assistance programs outside of this state.

26 ~~(14)~~~~(8)~~ If *the cabinet or* an enrollment or benefit tracking agency associated with the
 27 Medicaid program or the Supplemental Nutrition Assistance Program ~~of the~~

1 cabinet] receives information concerning an individual enrolled in the Medicaid
 2 program or the Supplemental Nutrition Assistance Program that indicates a change
 3 in circumstances that ~~would~~[may] affect eligibility, **the cabinet or** the enrollment or
 4 benefit tracking agency or other appropriate agency shall:

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

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

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

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

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

1 2015(o)(6).

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

5 ~~(16)~~~~(10)~~ The cabinet shall, in accordance with KRS Chapter 13A, promulgate ~~all rules~~
6 ~~and~~ administrative regulations necessary for the purposes of carrying out this
7 section.

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

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

15 (1) As used in this section:

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

17 (b) "Period of presumptive eligibility" has the same meaning as in 42 C.F.R. sec.
18 435.1101; and

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

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

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

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

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

1 department; and

2 (c) The location of the individual's local Department for Community Based
3 Services office.

4 (4) Notwithstanding any other provision of law to the contrary and to the extent
5 permitted under federal law, a pregnant individual shall be limited to one (1) period
6 of presumptive eligibility per pregnancy.

7 (5) (a) The department shall provide training on all applicable state and federal laws
8 related to presumptive eligibility to all qualified hospitals.

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

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

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

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

25 (1) A needy aged person, a needy blind person, a needy child, a needy permanently and
26 totally disabled person, or a person with whom a needy child lives shall be eligible
27 to receive a public assistance grant only if he or she has made a proper application

1 or an application has been made on his or her behalf in the manner and form
2 prescribed by administrative regulation. No individual shall be eligible to receive
3 public assistance under more than one (1) category of public assistance for the same
4 period of time.

5 (2) The secretary shall, by administrative regulations, prescribe the conditions of
6 eligibility for public assistance in conformity with the public assistance titles of the
7 Social Security Act, its amendments, and other federal acts and regulations. The
8 secretary shall also promulgate administrative regulations to allow for between a
9 forty percent (40%) and a forty-five percent (45%) ratable reduction in the method
10 of calculating eligibility and benefits for public assistance under Title IV-A of the
11 Federal Social Security Act. In no instance shall grants to families with no income
12 be less than the appropriate grant maximum used for public assistance under Title
13 IV-A of the Federal Social Security Act. As used in this section, "ratable reduction"
14 means the percentage reduction applied to the deficit between the family's
15 countable income and the standard of need for the appropriate family size.

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

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

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

27 (6) The cabinet shall promptly notify the appropriate law enforcement officials of the

1 furnishing of public assistance under Title IV-A of the Federal Social Security Act
2 in respect to a child who has been deserted or abandoned by a parent.

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

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

7 (b) To accept suitable training, or

8 (c) To accept suitable employment.

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

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

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

22 (10) (a) For the purpose of determining eligibility for medical assistance under Title
23 XIX of the Social Security Act and compliance with 42 U.S.C. sec.
24 1396a(xx) and Section 1 of this Act, unless otherwise required by federal law,
25 the cabinet shall only accept self-attestation of income, residency, age,
26 household composition, caretaker or relative status, or receipt of other
27 coverage as verification of last resort prior to enrollment, and the cabinet shall

1 not request federal authorization or approval to waive or decline to
2 periodically check any available income-related data source to verify
3 eligibility.

4 (b) This subsection shall not apply to any individual who is a resident of an
5 assisted living community as defined in KRS 194A.700 or to a long-term care
6 facility as defined in KRS 216A.010 or hospital licensed under KRS Chapter
7 216B that is using self-attestation to determine presumptive eligibility.

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

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

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

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

24 (b) May:

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

- 1 2. Upon the second violation, deem the individual ineligible for all public
2 assistance programs administered by the cabinet under this chapter for a
3 period of not more than twelve (12) months; and
- 4 3. Upon the third violation, deem the individual ineligible for all public
5 assistance programs administered by the cabinet under this chapter for a
6 period of not more than five (5) years.
- 7 (13) (a) Notwithstanding any other provision of Kentucky law, the following shall be
8 disregarded for the purposes of determining an individual's eligibility for a
9 means-tested public assistance program, and the amount of assistance or
10 benefits the individual is eligible to receive under the program:
- 11 1. Any amount in an ABLE account;
- 12 2. Any contributions to an ABLE account; and
- 13 3. Any distribution from an ABLE account for qualified disability
14 expenses.
- 15 (b) As used in ~~For purposes of~~ this subsection:
- 16 1. "ABLE account" means an account established within any state having a
17 qualified ABLE program as provided in 26 U.S.C. sec. 529A, as
18 amended;
- 19 2. "Kentucky law" includes:
- 20 a. All provisions of the Kentucky Revised Statutes;
- 21 b. Any contract to provide Medicaid managed care established
22 pursuant to this chapter;
- 23 c. Any agreement to operate a Medicaid program established
24 pursuant to this chapter; and
- 25 d. Any administrative regulation promulgated pursuant to this
26 chapter; and
- 27 3. "Qualified disability expenses" means expenses described in 26 U.S.C.

1 sec. 529A of a person who is the beneficiary of an ABLE account.

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

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

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

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

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

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

20 *(b) Contracting with a vendor or other subcontractor for the purpose of*
21 *engaging in activities the managed care organization is prohibited from*
22 *engaging in under paragraph (a) of this subsection;*

23 *(c) Penalizing a primary care provider for the primary care provider's inability*
24 *to make contact with a Medicaid enrollee that has been assigned to the*
25 *primary care provider's roster if the primary care provider has made a*
26 *good-faith effort, as defined by the Department for Medicaid Services in its*
27 *contract with a managed care organization, to contact the enrollee;*

1 (d) Advertising or otherwise marketing the Medicaid program except to indicate
2 the managed care organization's participation in the Medicaid program;
3 and

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

7 2. As used in this paragraph, "inactive Medicaid provider" means an
8 enrolled Medicaid provider who has submitted fewer than one (1)
9 encounter or claim for payment for Medicaid covered services to a
10 given managed care organization within the pervious twelve (12)
11 months;

12 (2) The managed care organization shall be required to:

13 (a) Notify the Department for Medicaid Services and the Social Security
14 Administration in the appropriate county within five (5) business days of
15 receiving notice from any source of the death of a Medicaid enrollee served
16 by the managed care organization;

17 (b) Collaborate with the Department for Medicaid Services to implement and
18 execute a value-based payment model that aligns incentives for enrollees,
19 providers, managed care organizations, and the Commonwealth to improve
20 quality and health care outcomes. The value-based payment model required
21 under this subsection shall include a two percent (2%) withhold from each
22 managed care organization's capitation amount that can be earned back in
23 full or in part by the managed care organization through the achievement
24 of designated value-based measures that shall include but not be limited to:

25 1. Hospital readmission rates;

26 2. Cancer screening rates;

27 3. Child and adolescent well care visits;

- 1 4. Prenatal and postpartum care;
- 2 5. Emergency department utilization rates;
- 3 6. Behavioral health treatment and counseling services; and
- 4 7. Recovery services; and

5 (c) Comply with:

- 6 1. This section and Sections 3, 12, 13, and subsection (2) of Section 6 of
7 this Act;
 - 8 2. All terms, conditions, requirements, performance standards, and
9 obligations created under or included in the contract between the
10 managed care organization and the cabinet for the delivery of
11 Medicaid services;
 - 12 3. KRS 304.17A-708; and
 - 13 4. All sections of Subtitle 17A of KRS Chapter 304 listed in KRS
14 205.522;
- 15 (3) (a) If the Department for Medicaid Services receives mail returned as
16 undeliverable following an attempt to contact a Medicaid beneficiary by
17 first-class mail, the department shall make a good-faith effort to obtain the
18 beneficiary's current and correct address. The good-faith effort shall
19 include:
- 20 1. First, requesting the beneficiary's current and correct address from
21 his or her managed care organization;
 - 22 2. Accessing and reviewing all available state and federal data sources,
23 including but not limited to the National Change of Address database,
24 from which the department might obtain the beneficiary's current and
25 correct address; and
 - 26 3. Attempting to obtain the beneficiary's current and correct address
27 directly from the beneficiary by attempting to contact him or her

1 through at least two (2) of the following means of communication:

2 a. Telephone;

3 b. Text message; and

4 c. Email message.

5 (b) 1. The good-faith effort required under paragraph (a) of this subsection
6 shall continue for at least thirty (30) days after the date on which the
7 department first requested the beneficiary's current and correct
8 address from his or her managed care organization.

9 2. If the department is able to obtain the beneficiary's current and
10 correct address, the department shall resend any mail that was
11 returned to the department as undeliverable.

12 3. If the department is not able to obtain the beneficiary's current and
13 correct address within thirty (30) days after the date on which the
14 department first requested the beneficiary's current and correct
15 address from his or her managed care organization, the department
16 shall, to the extent permitted under federal law, disenroll the
17 individual from the Medicaid program pending any appeal that may
18 be required or guaranteed under federal law;

19 (4) The Department for Medicaid Services shall, in all instances, exercise its rights
20 under a contract with a Medicaid managed care organization to impose all
21 remedies available to the department under the terms of the contract, at law, or
22 equity if the department determines that the managed care organization or a
23 subcontractor acting on behalf of the managed care organization has:

24 (a) Violated any provision of the contract between the department and the
25 managed care organization; or

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

- 1 and
- 2 (5) (a) Penalties for violations of state and federal law related to the Medicaid
3 program, including but not limited to this section, and any other contract
4 requirements or prohibitions imposed upon the managed care organization
5 by the cabinet, including but not limited to:
- 6 1. The penalty for a violation of subsection (1)(a) or (b) of this section
7 shall be at least five hundred dollars (\$500) for each claim a managed
8 care organization requests or incentivizes a provider to resubmit;
- 9 2. The penalty for a violation of subsection (1)(c) of this section shall be
10 at least one thousand dollars (\$1,000) per violation;
- 11 3. The penalty for a violation of subsection (1)(d) of this section shall be
12 at least five thousand dollars (\$5,000) per violation;
- 13 4. The penalty for a violation of subsection (1)(e) of this section shall be
14 at least ten thousand dollars (\$10,000) for each inactive provider
15 included in an analysis of network adequacy; and
- 16 5. The penalty for a violation of subsection (2)(a) of this section shall be
17 at least one thousand dollars (\$1,000) per violation.
- 18 (b) All penalties and fines imposed or assessed against a Medicaid managed
19 care organization by the Cabinet for Health and Family Services, including
20 but not limited to those penalties established in paragraph (a) of this
21 subsection, shall be deposited into the Medicaid managed care organization
22 compliance fund established in Section 11 of this Act.

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

- 25 (1) (a) There is hereby established in the State Treasury a restricted fund to be
26 known as the Medicaid managed care organization compliance fund.
- 27 (b) The fund shall consist of all penalties or fines imposed by the cabinet on a

1 managed care organization for violations of Section 10 of this Act, any
 2 other contract violation, or any violation of state or federal law related to
 3 the Medicaid program, regardless of the manner in which the penalty of
 4 fine is paid by a managed care organization, including but not limited to
 5 reductions in future capitation payments or any monies withheld by the
 6 Department for Medicaid Services for payment of penalties or fines.

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

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

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

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

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

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

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

26 (1) [~~By January 1, 2019,]~~A managed care organization shall **maintain**[~~establish~~] an

27 interactive **website**[~~Web site~~], operated by the managed care organization, that

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

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

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

11 **1. Behavioral health;**

12 **2. Physical health; and**

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

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

16 **1. Internal appeals; and**

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

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

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

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

24 (a) Provide:

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

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

1 or resubmit claims to obtain correct payment. ~~A~~~~No~~ claim shall ***not*** be
 2 denied for timely filing if the initial claim was timely submitted;~~and~~

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

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

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

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

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

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

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

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

27 ***3.*** ***Only recoup denied payments or issue a demand for payment from a***

1 provider upon the final disposition of the audit, including the appeals
2 process established in KRS 205.646; and

3 4. Base recoupment of claims on the actual overpayment or
4 underpayment of claims unless the provider agrees to a settlement to
5 the contrary.

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

7 1. "Timely" means that an authorization or preauthorization request shall
8 be approved:

9 a. For an expedited authorization request, within twenty-four
10 (24) ~~seventy two (72)~~ hours after receipt of the request. The
11 timeframe for an expedited authorization request may be extended
12 by up to fourteen (14) days if:

- 13 i. The enrollee requests an extension; or
- 14 ii. The Medicaid managed care organization justifies to the
15 department a need for additional information and how the
16 extension is in the enrollee's interest; and

17 b. For a standard authorization request, within five (5) calendar ~~two~~
18 (2) business days. The timeframe for a standard authorization
19 request may be extended by up to fourteen (14) additional days if:

- 20 i. The provider or enrollee requests an extension; or
- 21 ii. The Medicaid managed care organization justifies to the
22 department a need for additional information and how the
23 extension is in the enrollee's interest; and

24 2. a. "Expedited authorization request" means a request for
25 authorization or preauthorization where the provider determines
26 that following the standard ~~a~~ timeframe could seriously
27 jeopardize an enrollee's life or health, or ability to attain, maintain,

1 or regain maximum function.~~[- and]~~

2 b. A request for authorization or preauthorization for treatment of an
3 enrollee with a diagnosis of substance use disorder shall be
4 considered an expedited authorization request by the provider and
5 the managed care organization.

6 (b) A decision by a managed care organization on an authorization or
7 preauthorization request for physical, behavioral, or other medically necessary
8 services shall be made in a timely and consistent manner so that Medicaid
9 members with comparable medical needs receive a comparable, consistent
10 level, amount, and duration of services as supported by the member's medical
11 condition, records, and previous affirmative coverage decisions.

12 (3) (a) Each managed care organization shall report on a monthly basis to the
13 department:

14 1. The number and dollar value of claims received that were denied,
15 suspended, or approved for payment;

16 2. The number of requests for authorization of services and the number of
17 such requests that were approved and denied;

18 3. The number of internal appeals and grievances filed by members and by
19 providers and the type of service related to the grievance or appeal, *the*
20 *total dollar amount of all denials being appealed*, the time of
21 resolution, the number of internal appeals and grievances where the
22 initial denial was overturned and the type of service and dollar amount
23 associated with the overturned denials;~~[- and]~~

24 4. *For each internal appeal or grievance not resolved within sixty (60)*
25 *calendar days, the name of the provider who filed the unresolved*
26 *internal appeal or grievance, the dollar amount of the claim that was*
27 *denied if a denial is being appealed, the reason for the delay in*

1 resolving the internal appeal or grievance, the current status of the
2 internal appeal or grievance, and the outcome determination if
3 rendered prior to the filing of the report; and

4 5. Any other information required by the department.

5 (b) The data required in paragraph (a) of this subsection shall be separately
6 reported by provider category, as prescribed by the department, and shall at a
7 minimum include inpatient acute care hospital services, inpatient psychiatric
8 hospital services, outpatient hospital services, residential behavioral health
9 services, and outpatient behavioral health services.

10 (4) On a monthly basis, the department shall transmit to the Department of Insurance a
11 report of each corrective action plan, fine, or sanction assessed against a Medicaid
12 managed care organization for violation of a Medicaid managed care organization's
13 contract relating to prompt payment of claims. The Department of Insurance shall
14 then make a determination of whether the contract violation was also a violation of
15 KRS 304.17A-700 to 304.17A-730.

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

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

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

1 (c) The number of internal appeals and grievances filed by Medicaid enrollees
 2 and by providers, the types of services to which the internal appeals and
 3 grievances relate, the total dollar amount of denials that were appealed, the
 4 average length of time to resolution, the number of internal appeals and
 5 grievances where the initial denial was overturned, and the types of services
 6 and dollar amount of overturned denials; and

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

11 **(6)** Any Medicaid managed care organization that fails to comply with subsection
 12 (1)(d)2. of this section or KRS 205.522, 205.532 to 205.536, ~~or~~ ~~and~~ 304.17A-515
 13 may be subject to fines, penalties, and sanctions, up to and including termination, as
 14 established under its Medicaid managed care contract with the department.

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

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

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

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

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

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

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

3 **a. Actuarially sound;**

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

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

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

16 **(c) Require regional brokers to:**

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

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

23 **3. a. Ensure that all vehicles used to provide Medicaid-covered**
24 **nonemergency medical transportation services are equipped with**
25 **a global positioning system device that enables the broker to**
26 **determine the precise location of the vehicle at all times when the**
27 **vehicle is being operated to provide nonemergency medical**

1 transportation services.

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

7 4. Collaborate with the Department for Medicaid Services, or another
8 agency in state government or a private entity with which the
9 department has contracted for the administration of a nonemergency
10 medical transportation service program, to implement and execute a
11 performance-based payment model that aligns incentives for Medicaid
12 enrollees, drivers, regional brokers, and the Commonwealth to
13 improve quality, reliability, and cost-effectiveness in the
14 nonemergency medical transportation service program. The
15 performance-based payment model required under this subparagraph
16 shall include a two percent (2%) withhold from each regional broker's
17 capitation amount that can be earned back in full or in part by the
18 regional transportation broker through achievement of designated
19 performance-based measures which shall:

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

22 b. Include but not be limited to:

23 i. Utilization rates;

24 ii. The number of nonemergency medical transportation
25 service trips completed;

26 iii. The number of nonemergency medical transportation
27 service trips canceled or rescheduled;

- 1 iv. The number of delayed nonemergency medical
2 transportation service trips;
3 v. Average trip time;
4 vi. Average miles per trip;
5 vii. The amount of time required to schedule a nonemergency
6 medical transportation service; and
7 viii. Rider satisfaction.

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

10 (b) For the state fiscal year beginning July 1, 2027, regional brokers shall be
11 required to achieve a medical loss ratio of at least eighty-seven percent
12 (87%).

13 (c) For the state fiscal year beginning July 1, 2028, regional brokers shall be
14 required to achieve a medical loss ratio of at least eighty-nine percent
15 (89%).

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

19 (4) Utilization rates for nonemergency medical transportation services, including
20 when calculated by an actuary under subsection (2) of this section, shall consider
21 only nonemergency medical transportation service eligible Medicaid enrollees, as
22 determined by the Department for Medicaid Services in accordance with
23 subsection (2)(c) of Section 5 of this Act, within a given region and shall not be
24 based on the total number of Medicaid enrollees.

25 (5) (a) A skilled nursing facility or hospital shall be permitted to provide
26 nonemergency medical transportation services for residents of the skilled
27 nursing facility or patients of the hospital if the transportation service would

1 be considered a Medicaid-covered service if provided by a driver contracted
2 by a nonemergency medical transportation service regional broker.

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

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

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

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

26 (a) Utilization rates;

27 (b) The number of nonemergency medical transportation service trips

- 1 completed;
- 2 (c) The number of nonemergency medical transportation service trips cancelled
- 3 or rescheduled, including the reason for cancellation or rescheduling;
- 4 (d) The number of delayed nonemergency medical transportation service trips;
- 5 (e) Average trip time;
- 6 (f) Average miles per trip;
- 7 (g) The amount of time required to schedule a nonemergency medical
- 8 transportation service;
- 9 (h) Rider satisfaction; and
- 10 (i) The performance-based payment model required under subsection (5) of
- 11 this section.

12 ➔SECTION 15. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO

13 READ AS FOLLOWS:

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

- 15 (a) "Department":
- 16 1. Means the Department for Medicaid Services; and
- 17 2. Includes any other agency of state government or nongovernmental
- 18 entity contracted by the department to administer any aspect of a
- 19 waiver program;
- 20 (b) "Waiver program" means a 1915(c) home and community-based waiver
- 21 program approved by the federal Centers for Medicare and Medicaid
- 22 Services and administered by the department or any other subdivision of the
- 23 cabinet; and
- 24 (c) "Waiver program application" means any waiver program application,
- 25 including a waiver waitlist application or application to begin receiving
- 26 waiver program services.

27 (2) (a) The department shall require any individual applying for waiver program

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

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

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

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

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

1 subsection shall:

2 (a) Be nationally recognized;

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

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

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

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

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

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

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

1 (c) This subsection shall not apply to:

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

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

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

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

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

1 required under KRS 205.8465.

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

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

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

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

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

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

1 Services, and the Medicaid program;

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

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

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

20 (f) Providing the General Assembly with continuous and ongoing access to
21 data, evidence, records, and information pertaining to the Medicaid
22 program and the administration thereof is critical to ensuring that the
23 General Assembly is able to conduct the thorough and systematic
24 evaluations that are a necessary precursor to the body's effective and
25 meaningful discharge of its oversight, policy-making, and appropriation
26 duties.

27 (2) (a) No later than fourteen (14) calendar days after the effective date of this Act,

1 the cabinet shall provide the Commission with a comprehensive and
2 exhaustive list of all databases, datasets, electronic records, and files
3 pertaining to the Medicaid program or any aspect thereof that are
4 maintained by or in the possession of the cabinet or any of its various
5 departments and divisions.

6 (b) No later than thirty (30) calendar days after the effective date of this Act,
7 the director of the Commission shall provide the cabinet with a list of
8 databases, datasets, electronic records, and files determined by the director
9 to be necessary for the meaningful and effective discharge of legislative
10 duties, including oversight, policy making, and the appropriation of funds to
11 provide for the administration of the Medicaid program by the General
12 Assembly.

13 (c) No later than July 1, 2026, the cabinet shall provide the General Assembly
14 with continuous and ongoing access to all databases, datasets, electronic
15 records, and files determined by the director of the Commission to be
16 necessary for the meaningful and effective discharge of legislative duties,
17 including oversight, policy making, and the appropriation of funds to
18 provide for the administration of the Medicaid program by the General
19 Assembly.

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

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

- 1 (b) Consult with the director of the Commission and the Kentucky Office of
2 Information Technology on the manner and method by which access is
3 provided; and
- 4 (c) Provide training on methods to access the databases, datasets, electronic
5 records, and files in a secure manner to the director of the Commission and
6 any nonpartisan employee thereof designated by the director.
- 7 (4) The Commission and the cabinet may enter into a memorandum of
8 understanding governing the Commission's access to the shared databases,
9 datasets, electronic records, and files. Any memorandum of understanding that
10 may be entered into under this subsection:
- 11 (a) Shall not preclude or prohibit the Commission from providing information
12 shared with the Commission under this section to any vendor or entity with
13 which the Commission may contract for the purpose of analyzing,
14 reviewing, studying, investigating, or evaluating the Medicaid program or
15 any aspect thereof, including but not limited to any vendor with which the
16 Commission may contract pursuant to Section 20 of this Act;
- 17 (b) May include requirements for otherwise ensuring and maintaining the
18 confidentiality and security of all databases, datasets, electronic records,
19 and files shared with the Commission under this section, including but not
20 limited to requirements that may be necessary to comply with the Health
21 Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191;
22 and
- 23 (c) Shall be no more restrictive than any other current memorandum of
24 understanding between the cabinet and any other entity governing access to
25 data shared with the Commission under this section.
- 26 (5) The list of databases, datasets, electronic records, and files submitted by the
27 director of the Commission pursuant to subsection (2)(b) of this section may be

1 amended by the director of the Commission as the needs of the General Assembly
2 change. When the cabinet is notified of such an amendment, the cabinet shall
3 ensure that the Commission is provided with access to any newly requested
4 databases, datasets, electronic records, or files within thirty (30) calendar days.

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

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

13 2. Any report required under 42 C.F.R. sec. 433, or 42 C.F.R. sec. 438
14 Subpart B or E;

15 3. Any report or data that may be submitted to the cabinet by any vendor
16 or entity with which the cabinet has contracted for administration,
17 examination, study, or review of any aspect of the Medicaid program,
18 including but not limited to:

19 a. Medicaid managed care capitation rate certifications;

20 b. Nonemergency medical transportation rate certifications; and

21 c. Any medical loss ratio reports that require approval by the
22 federal Centers for Medicare and Medicaid Services; and

23 4. Any other report or action that requires approval by the federal
24 Centers for Medicare and Medicaid Services.

25 (b) All reports required to be provided to the Commission under this subsection
26 shall be provided within thirty (30) calendar days of the date on which the
27 report is completed or delivered to the cabinet.

1 ➔SECTION 17. A NEW SECTION OF KRS 7A.270 TO 7A.290 IS CREATED
2 TO READ AS FOLLOWS:

3 *(1) In order to facilitate the board's ongoing efforts to continuously improve health*
4 *outcomes in a cost-efficient and effective manner, the Commission shall*
5 *collaborate with the University of Kentucky and the University of Louisville to*
6 *design and develop a web-based healthcare transparency dashboard that tracks,*
7 *at a minimum:*

8 *(a) Leading health indicators;*

9 *(b) Performance indicators for Medicaid managed care organizations;*

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

11 *(d) Performance indicators for the department.*

12 *(2) Performance indicators for Medicaid managed care organizations shall include*
13 *but not be limited to:*

14 *(a) Follow-up after emergency department visits;*

15 *(b) Cancer screenings;*

16 *(c) Child and adolescent well-care visits;*

17 *(d) Postpartum care;*

18 *(e) Diabetes care and management; and*

19 *(f) Hypertension care and management.*

20 *(3) The healthcare transparency dashboard shall be:*

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

23 *(b) Maintained and operated by the Commission.*

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

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

27 (1) Require any of the following entities to provide any and all information necessary

1 to carry out the board's duties, including any contracts entered into by the
2 department, the cabinet, or any other state agency related to the administration of
3 any aspect of the Medicaid program or the delivery of Medicaid benefits or
4 services:

- 5 (a) The cabinet;
- 6 (b) The department;
- 7 (c) Any other state agency;
- 8 (d) Any Medicaid managed care organization with whom the department has
9 contracted for the delivery of Medicaid services;
- 10 (e) The state pharmacy benefit manager contracted by the department pursuant to
11 KRS 205.5512; and
- 12 (f) Any other entity contracted by a state agency to administer or assist in
13 administering any aspect of the Medicaid program or the delivery of Medicaid
14 benefits or services;

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

18 (3) Conduct public hearings in furtherance of its general duties, at which it may request
19 the appearance of officials of any state agency and solicit the testimony of
20 interested groups and the general public;

21 (4) Establish any advisory committees or subcommittees of the board that the board
22 deems necessary to carry out its duties **and upon approval of the Commission:**

23 **(a) Include in the membership of an advisory committee or subcommittee**
24 **individuals who are not members of the board; and**

25 **(b) Appoint as co-chairs of an advisory committee or subcommittee individuals**
26 **who are not members of the General Assembly;**

27 (5) Recommend that the Auditor of Public Accounts perform a financial or special

1 audit of the Medicaid program or any aspect thereof; and

2 (6) Subject to selection and approval by the ~~Legislative Research~~ Commission, utilize
3 the services of consultants, analysts, actuaries, legal counsel, and auditors to render
4 professional, managerial, and technical assistance, as needed.

5 ➔Section 19. KRS 7A.286 is amended to read as follows:

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

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

13 (b) On an ongoing basis, review any change or proposed change in federal laws
14 and regulations governing the Medicaid program and report to the Legislative
15 Research Commission on the probable costs, possible budgetary implications,
16 potential effect on healthcare outcomes, and the overall desirability of any
17 change or proposed change in federal laws or regulations governing the
18 Medicaid program;

19 (c) At the request of the Speaker of the House of Representatives or the President
20 of the Senate, evaluate proposed changes to state laws affecting the Medicaid
21 program and report to the Speaker or the President on the probable costs,
22 possible budgetary implications, potential effect on healthcare outcomes, and
23 overall desirability as a matter of public policy;

24 (d) At the request of the ~~Legislative Research~~ Commission, research issues
25 related to the Medicaid program;

26 (e) Beginning in 2027~~[2026]~~ and at least once every five (5) years thereafter,
27 cause;

1 **1.** A review to be made of the administrative expenses and operational cost
 2 of the Medicaid program. The review shall include but not be limited to
 3 evaluating the level and growth of administrative costs, the potential for
 4 legislative changes to reduce administrative costs, and administrative
 5 changes the department may make to reduce administrative costs or
 6 staffing needs. At the discretion of the ~~{Legislative Research~~
 7 ~~}Commission~~, the review may be conducted by a consultant retained by
 8 the board;

9 **2. A program evaluation to be conducted of the Medicaid program. In**
 10 **any instance in which a program evaluation indicates inadequate**
 11 **operating or administrative system controls or procedures,**
 12 **inaccuracies, inefficiencies, waste, extravagance, unauthorized or**
 13 **unintended activities, or other deficiencies, the board shall report its**
 14 **findings to the Commission. The program evaluation shall be**
 15 **performed by a consultant retained by the board; and**

16 **3. An actuarial analysis to be performed of the Medicaid program, to**
 17 **evaluate the sufficiency and appropriateness of Medicaid**
 18 **reimbursement rates established by the department and those paid by**
 19 **any managed care organization contracted by the department for the**
 20 **delivery of Medicaid services. The actuarial analysis shall be**
 21 **performed by an actuary retained by the board;**

22 (f) ~~{Beginning in 2027 and at least once every five (5) years thereafter, cause a~~
 23 ~~program evaluation to be conducted of the Medicaid program. In any instance~~
 24 ~~in which a program evaluation indicates inadequate operating or~~
 25 ~~administrative system controls or procedures, inaccuracies, inefficiencies,~~
 26 ~~waste, extravagance, unauthorized or unintended activities, or other~~
 27 ~~deficiencies, the board shall report its findings to the Legislative Research~~

1 ~~Commission. The program evaluation shall be performed by a consultant~~
2 ~~retained by the board;~~

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

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

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

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

23 (a) Review all new or amended administrative regulations related to the Medicaid
24 program and provide comments to the Administrative Regulation Review
25 Subcommittee established in KRS 13A.020;

26 (b) Make recommendations to the General Assembly, the Governor, the secretary
27 of the cabinet, and the commissioner of the department regarding program

1 administration, including benefits and coverage policies, access to services
 2 and provider network adequacy, healthcare outcomes and disparities,
 3 reimbursement rates, payment methodologies, delivery system models,
 4 funding, and administrative regulations. Recommendations made pursuant to
 5 this section shall be nonbinding and shall not have the force of law; and

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

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

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

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

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

24 (b) Make any change *related* to eligibility, coverage, or benefits in the Medicaid
 25 program, including by pursuing or applying for a waiver of federal Medicaid
 26 law under Title 42 of the United States Code, seeking to amend or renew an
 27 existing waiver granted under Title 42 of the United States Code, or pursuing

1 a state plan amendment, without first obtaining specific authorization from the
2 General Assembly to do so; or

3 (c) Provide any Medicaid benefit or expend general fund moneys on any
4 Medicaid benefit not expressly authorized by the General Assembly or
5 required under federal law.

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

19 (3) If the cabinet seeks authorization from the General Assembly to renew an existing
20 waiver granted under Title 42 of the United States Code, the cabinet shall be
21 required to submit a fiscal impact assessment as described in subsection (2) of this
22 section and an assessment of the efficacy and necessity of the existing waiver. The
23 assessments required by this subsection shall be submitted to the Legislative
24 Research Commission for referral to the Interim Joint Committee on Appropriations
25 and Revenue, the Interim Joint Committee on Families and Children, the Interim
26 Joint Committee on Health Services, and the Office of Budget Review at least
27 twelve (12) calendar months prior to the date on which the existing waiver is set to

1 expire.

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

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

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

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

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

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

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

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

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

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

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

9 (b) Medicaid directed or supplemental payment programs initially approved by
 10 the federal Centers for Medicare and Medicaid Services prior to March 27,
 11 2025, including but not limited to:

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

15 2. Any other payment program for a university hospital as defined in KRS
 16 205.639; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (2) As used in this section:

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

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

20 (3) The department shall:

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

23 1. Be licensed under KRS Chapter 313;

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

25 3. Be responsible for overseeing the administration of Medicaid-covered
26 dental services;

27 (b) Consider any recommendations that may be made by the Medicaid

- 1 Oversight and Advisory Board, or a subcommittee thereof, regarding the
2 transition of Medicaid-covered dental services from a managed care
3 delivery model to an ASO delivery model;
- 4 (c) In accordance with KRS Chapter 45A and subsection (5) of this section,
5 select and contract with a third-party ASO to administer Medicaid-covered
6 dental services. The contract entered into under this paragraph shall have
7 an effective date of January 1, 2029;
- 8 (d) Promulgate administrative regulations in accordance with KRS Chapter
9 13A to implement this section;
- 10 (e) Beginning January 1, 2029:
- 11 1. Transition all Medicaid beneficiaries from Medicaid managed care
12 organization coverage into ASO coverage for the administration of all
13 Medicaid-covered dental services; and
- 14 2. Establish a Dental Services Advisory Panel which shall:
- 15 a. Include the following members:
- 16 i. The Medicaid dental director employed pursuant to
17 paragraph (a) of this subsection;
- 18 ii. The members of Technical Advisory Committee on Dental
19 Care established in KRS 205.590; and
- 20 iii. A representative from the ASO contracted with pursuant to
21 paragraph (c) of this subsection;
- 22 b. Be attached to the department for administrative purposes; and
- 23 c. Provide ongoing consultation, recommendations, and guidance
24 to the department to continually improve administration and
25 delivery of Medicaid-covered dental services; and
- 26 (f) On January 1, 2029, begin utilizing an ASO delivery model for the
27 administration of all Medicaid-covered dental services.

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

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

8 1. Assisting with and facilitating the transitioning of all Medicaid
9 beneficiaries from Medicaid managed care organization coverage into
10 ASO coverage for dental services;

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

14 3. Employing utilization control strategies established by the department
15 and managing all prior authorization requests for Medicaid-covered
16 dental services;

17 4. Providing coordination of care with a Medicaid beneficiary's
18 Medicaid managed care organization;

19 5. Providing customer service and support to Medicaid beneficiaries and
20 Medicaid-participating dental providers; and

21 6. Any other administrative duties or responsibilities contractually
22 assigned to the ASO by the department.

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

26 (5) (a) Notwithstanding any provision of law to the contrary including subsection
27 (3)(c) of this section, the department shall not initiate a procurement

1 process to contract with a third-party ASO to administer Medicaid-covered
 2 dental services prior to January 1, 2028.

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

6 (6) On an annual basis, the department, in collaboration with the Dental Services
 7 Advisory Panel, shall:

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

10 1. Accuracy and timeliness of claims processing;

11 2. Efficiency of processing prior authorization requests;

12 3. Observed network adequacy improvements;

13 4. Availability of and access to services; and

14 5. Satisfaction ratings from participating dental service providers and
 15 Medicaid beneficiaries; and

16 (b) Prepare and submit a report on the evaluation required under this
 17 subsection to the Legislative Research Commission for referral to the
 18 Interim Joint Committees on Appropriations and Revenue and Health
 19 Services, and the Medicaid Oversight and Advisory Board by August 1,
 20 2029, and August 1 of each year thereafter.

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

22 205.515 Medicaid program delivery system.

23 311A.172 Provision of nonemergency medical transportation services to a resident by a
 24 skilled nursing facility or hospital -- Conditions.

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

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

3 (b) Consider strategies implemented by other states to manage demand for
4 1915(c) waiver services;

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

7 (d) Receive testimony and reports from the Cabinet for Health and Family
8 Services related to waiver waitlist management strategies required under subsection (2)
9 of this Section;

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

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

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

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

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

23 ➔Section 27. If the Cabinet for Health and Family Services or the Department for
24 Medicaid Services determines that a state plan amendment, waiver, or any other form of
25 authorization or approval from any federal agency to implement Sections 1, 2, 3, 4, 5, 6,
26 7, 8, 9, 10, 11, 13, 14, or 15 of this Act is necessary to prevent the loss of federal funds or
27 to comply with federal law, the cabinet or department:

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

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

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

9 ➔Section 29. The Medicaid Oversight and Advisory Board, established in KRS
10 7A.273, is hereby directed to evaluate the Medicaid nonemergency medical
11 transportation, or NEMT, program during the 2026 Legislative Interim. As part of the
12 evaluation directed by this section the board shall:

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

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

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

20 (b) The regional broker system; and

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

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

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

26 (5) Identify strategies to:

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

- 1 (b) Improve transportation service accessibility, availability, and reliability;
- 2 (c) Improve customer satisfaction; and
- 3 (d) Enhance administrative efficiencies; and
- 4 (6) Submit a report of the board's findings and recommendations related to the
- 5 Medicaid NEMT program to the Legislative Research Commission not later than
- 6 December 31, 2026.

7 ➔Section 30. Provisions of Section 26 and 29 of this Act to the contrary

8 notwithstanding, the Legislative Research Commission shall have the authority to

9 alternatively assign the issues identified therein to an interim joint committee or

10 subcommittee thereof, and to designate a study completion date.

11 ➔Section 31. Sections 26, 29, and 30 of this Act shall have the same legal status

12 as a House Concurrent Resolution.

13 ➔Section 32. (1) There is included in the Medicaid Administration Budget

14 Unit in the 2026-2028 State/Executive Branch Budget enacted in 2026 RS HB 500

15 sufficient funds to implement a community engagement pilot program for Medicaid

16 enrolled individuals who are subject to newly established federal demonstrated

17 community engagement requirements, and the Cabinet for Health and Family Services

18 shall distribute \$5,000,000 in each fiscal year of the 2026-2028 fiscal biennium to

19 Volunteers of America to support implementation and administration of the community

20 engagement pilot program described in this section.

21 (2) The community engagement pilot program shall:

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

23 (b) Utilize a coordinated case management technology platform capable of

24 tracking eligibility, participation, exemptions, compliance, outcomes, and real-time

25 communication between partners;

26 (c) Be implemented through a proven community alliance model that operates at

27 the local, county, level and integrate workforce, education, health, faith-based, nonprofit,

1 and social service partners;

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

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

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

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

11 (a) Establish the operational, technological, and community infrastructure
12 groundwork for full-scale federally required demonstrated community engagement
13 compliance by January 1, 2027; and

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

17 (4) Volunteers of America shall:

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

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

27 ➔Section 33. Whereas recently enacted federal changes to the Medicaid program

1 and significant increases in the Commonwealth's Medicaid budget over the last decade
2 create an urgent need to bolster legislative oversight of the Medicaid program, take
3 immediate steps to comply with new federal requirements, and ensure that Medicaid
4 expenditures support the healthcare needs of only those individuals the program is
5 intended to serve, an emergency is declared to exist, and this Act takes effect upon its
6 passage and approval by the Governor or upon its otherwise becoming a law.