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

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

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

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

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

(c) In the case of an applicable individual who is enrolled and receiving Medicaid benefits, in order to remain eligible for continued enrollment, at the time of eligibility redetermination, the individual shall be required to demonstrate community engagement for three (3) of the immediately preceding six (6) months prior to the month in which eligibility redetermination is conducted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 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 the promulgation of administrative regulations in accordance

with KRS Chapter 13A;

h. An inmate at a public institution or has not been an inmate of a public institution within the previous ninety (90) days;

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

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

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

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

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

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

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

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

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

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

the Internal Revenue Code of 1986~~[~~

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

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

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

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

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

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

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

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

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

(b) Primary care services;

(c) Mental health care services;

(d) Substance use disorder services;

(e) Any services provided by a:

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

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

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

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

(4) Cost-sharing requirements established under this section shall be in the form of copayments and shall not include any enrollment fees, premiums, deductibles, or any other form of cost sharing unless specifically authorized by the General Assembly.

(5) Except as provided in subsections (2), (3), and (7)(a) of this section, beginning January 1, 2027, through September 30, 2028, the following cost-sharing requirements shall be imposed against Medicaid enrolled individuals described in subsection (2) of this section:

(a) Nonemergency use of a hospital emergency department shall be subject to a copayment of eight dollars ($8);

(b) Prescription drugs shall be subject to a copayment requirement equal to the maximum amount permitted under 42 C.F.R. sec. 447.53 for individuals with a family income less than or equal to one hundred fifty percent (150%) of the federal poverty level;

(c) Inpatient hospital services shall be subject to a copayment of thirty-five dollars ($35); and

(d) Prescription glasses and contacts shall be subject to copayment of eight dollars ($8).

(6) Except as provided in subsections (3) and (7) of this section, beginning October 1, 2028, for care or an item or service furnished to a Medicaid enrolled individual described in subsection (2) of this section, the cost-sharing requirement established under this subsection shall be twenty dollars ($20).

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

(b) The cost-sharing requirement established under subsection (6) of this section for inpatient stays shall be thirty-five dollars ($35).

(c) The cost-sharing requirements established under subsection (6) of this section for a prescription drug shall be equal to the maximum amount allowed under 42 C.F.R. sec. 447.53.

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

(1) As used in this section:

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

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

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

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

2. Analysis of data;
3. Development of a lactation management and child feeding plan with demonstration and instruction to parents;
4. Provision of lactation and feeding education;
5. The recommendation and use of assistive devices;
6. Communication to the primary health care practitioner or practitioners and referral to other health care practitioners, as needed;
7. Appropriate follow-up with evaluation of outcomes; and
8. Documentation of the encounter in a patient record;

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

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

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

(a) For lactation consultation;

(b) For breastfeeding equipment;

(c) To pregnant and postpartum women for an in-home program; and

(d) For telehealth or digital health services that are related to maternity care associated with pregnancy, childbirth, and postpartum care.

(3) The coverage required by this section shall:

(a) Not be subject to:

1. Any cost-sharing requirements, including but not limited to copayments**,** ***except as may be required under Section 2 of this Act***; or
2. Utilization management requirements, including but not limited to prior authorization, prescription, or referral, except as permitted in paragraph

(d) of this subsection;

(b) Be provided in conjunction with each birth for the duration of breastfeeding, as defined by the beneficiary;

(c) For lactation consultation, include:

1. In-person, one-on-one consultation, including home visits, regardless of location of service provision;

2. The delivery of consultation via telehealth, as defined in KRS 205.510, if the beneficiary requests telehealth consultation in lieu of in-person, one-on-one consultation; or

3. Group consultation, if the beneficiary requests group consultation in lieu of in-person, one-on-one consultation; and

(d) For breastfeeding equipment, include:

1. Purchase of a single-user, double electric breast pump, or a manual pump in lieu of a double electric breast pump, if requested by the beneficiary;

2. Rental of a multi-user breast pump on the recommendation of a licensed health care provider; and

3. Two (2) breast pump kits as well as appropriately sized breast pump flanges and other lactation accessories recommended by a health care provider.

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

(b) If the department cannot ensure delivery of breastfeeding equipment in accordance with paragraph (a) of this subsection, an individual may purchase

equipment and the department or a managed care organization with whom the department contracts for the delivery of Medicaid services shall reimburse the individual for all out-of-pocket expenses incurred by the individual, including any balance billing amounts.

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

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

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

(a) Counseling requirements for medication;

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

(c) Copayments or other out-of-pocket cost sharing, including deductibles***, except as may be required under Section 2 of this Act***.

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

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

(b) For services associated with more than two (2) attempts to quit within a

twelve (12) month period.

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

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

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

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

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

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

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

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

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

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

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

(b) Except as provided in subsection (11) of Section 9 of this Act, issue an initial finding of ineligibility that may be appealed by the individual through the cabinet's established appeals process if the cabinet finds or reviews

inconsistent or contradictory data from the various data sources the cabinet is required to review under paragraph (a) of this subsection and any data source reflects that the individual whose eligibility is being determined or redetermined is ineligible to enroll in or continue to be enrolled in the Medicaid program; and

(c) Assess and make a determination about the individual's eligible for Medicaid-covered nonemergency medical transportation services.

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

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

(1) The cabinet shall:

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

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

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

1. That they are required to submit proof of current residency in the

Commonwealth within thirty (30) days;

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

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

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

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

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

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

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

c. That failure to submit proof of current residency in the Commonwealth within thirty (30) days shall result in the individual being disenrolled from the Kentucky Medicaid program;

(e) Not make capitation payments to any managed care organization with

whom the cabinet contracts for the delivery of Medicaid services on behalf of any individual disenrolled from managed care in accordance with paragraphs (c) and (d) of this subsection;

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

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

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

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

1. Enrolled in the Kentucky Medicaid program;

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

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

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

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

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

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

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

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

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

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

(2) On at least a monthly basis, each enrollment or benefit tracking agency associated with the Medicaid program or the Supplemental Nutrition Assistance Program of the cabinet shall receive and review information from the Vital Statistics Branch concerning individuals enrolled in the Medicaid program or the Supplemental Nutrition Assistance Program that ***may indicate***~~[indicates]~~ a change in circumstances that ***would***~~[may]~~ affect eligibility.

(3) On at least a quarterly basis, each enrollment or benefit tracking agency associated with the Medicaid program or the Supplemental Nutrition Assistance Program of the cabinet shall receive and review information from the~~[Kentucky]~~ Office of

Unemployment Insurance concerning individuals enrolled in the Medicaid program or the Supplemental Nutrition Assistance Program that ***may indicate***~~[indicates]~~ a change in circumstances that ***would***~~[may]~~ affect eligibility, including but not limited to changes in employment or wages.

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

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

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

(7) On at least a monthly basis, each enrollment or benefit tracking agency associated with the Medicaid program shall receive and review information from the Department of Corrections concerning individuals enrolled in the Medicaid

program that may indicate a change in circumstances that would affect eligibility for enrollment in the Medicaid program.

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

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

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

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

(10) ~~[(5)]~~ Notwithstanding any other provision of law to the contrary:

(a) ***The cabinet and*** each enrollment or benefit tracking agency associated with the Medicaid program or the Supplemental Nutrition Assistance Program~~[of the cabinet]~~ shall enter into a memorandum of understanding with any department, agency, or division for information detailed in this section; and

(b) Any department, agency, or division for information detailed in this section, including but not limited to the Kentucky Lottery Corporation, ***the Kentucky Horse Racing and Gaming Corporation,*** the Vital Statistics Branch, the Office of Unemployment Insurance, ~~[and]~~the Department for Community Based Services, ***the Kentucky Transportation Cabinet, the Department of Revenue, and the Department of Corrections,*** shall enter into any necessary memoranda of understanding with the ***cabinet or the*** enrollment or benefit tracking agency associated with the Medicaid program or the Supplemental

Nutrition Assistance Program requesting an agreement pursuant to paragraph (a) of this subsection.

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

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

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

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

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

(14) ~~[(9)]~~ (a) Unless expressly required by federal law or as permitted by this subsection, the cabinet shall not seek, apply for, accept, or renew any waiver of work requirements established by the Supplemental Nutrition Assistance

Program under 7 U.S.C. sec. 2015(o) without first obtaining specific authorization from the General Assembly to do so. The cabinet may, without first obtaining specific authorization from the General Assembly, request:

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

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

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

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

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

(16) ~~[(10)]~~ The cabinet shall, in accordance with KRS Chapter 13A, promulgate ~~[all rules~~

~~and ~~administrative regulations necessary for the purposes of carrying out this section.

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

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

(1) As used in this section:

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

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

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

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

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

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

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

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

3. The location of the individual's local Department for Community Based

Services office;

4. Notification that if the individual does not file a full Medicaid application before the last day of the following month, the period of presumptive eligibility coverage will end on that day; and

5. Notification that if the individual does file a full Medicaid application before the last day of the following month, presumptive eligibility coverage will continue until an eligibility determination is made on the application by the department;

(c) Issue a presumptive eligibility identification card or document to the presumed eligible individual;

(d) Maintain a record of the presumptive eligibility screening for each application; and

(e) Assist presumptively eligible individuals in completing ***and submitting*** a full Medicaid application and understanding any documentation requirements.

(3) If a qualified hospital determines that an individual does not meet the criteria for presumptive eligibility using information provided and attested to by the individual, the hospital shall provide the individual with written notification of:

(a) The reason for the determination;

(b) Notification that the individual may file a full Medicaid application through the individual's local Department for Community Based Services office if the individual wishes to have a formal determination of eligibility made by the department; and

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

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

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

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

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

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

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

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

(2) The secretary shall, by administrative regulations, prescribe the conditions of eligibility for public assistance in conformity with the public assistance titles of the

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

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

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

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

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

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

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

(b) To accept suitable training, or

(c) To accept suitable employment.

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

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

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

(10) (a) For the purpose of determining eligibility for medical assistance under Title XIX of the Social Security Act***, and compliance with 42 U.S.C. sec. 1396a(xx) and Section 1 of this Act***, unless otherwise required by federal law, the cabinet shall***:***

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

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

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

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

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

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

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

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

(b) May:

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

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

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

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

1. Any amount in an ABLE account;

2. Any contributions to an ABLE account; and

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

(b) For purposes of this subsection:

1. "ABLE account" means an account established within any state having a qualified ABLE program as provided in 26 U.S.C. sec. 529A, as amended;

2. "Kentucky law" includes:

a. All provisions of the Kentucky Revised Statutes:

b. Any contract to provide Medicaid managed care established pursuant to this chapter;

c. Any agreement to operate a Medicaid program established pursuant to this chapter; and

d. Any administrative regulation promulgated pursuant to this chapter; and

3. "Qualified disability expenses" means expenses described in 26 U.S.C. sec. 529A of a person who is the beneficiary of an ABLE account.

(14) (a) Residency shall not be established for an individual if the individual relocates to Kentucky with the sole intention of establishing eligibility to receive

medical services, including substance use disorder treatment services under this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Hospital readmission rates;

2. Cancer screening rates;

3. Child and adolescent well care visits;

4. Prenatal and postpartum care;

5. Emergency department utilization rates;

6. Behavioral health treatment and counseling services; and

7. Recovery services;

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

1. Timely claims processing and payment;

2. Provider network and network adequacy;

3. Utilization management;

4. Program integrity; and

5. Covered services; and

(d) Comply with:

1. This section and Sections 3, 12, 13, and subsection (2) of Section 6 of this Act;

2. All terms, conditions, requirements, performance standards, and obligations created under or included in the contract between the managed care organization and the cabinet for the delivery of Medicaid services;

3. KRS 304.17A-708; and

4. All sections of Subtitle 17A of KRS Chapter 304 listed in KRS 205.522;

(3) If the Department for Medicaid Services receives mail returned as undeliverable

following an attempt to contact a Medicaid beneficiary by first class mail, the department shall notify the beneficiary's managed care organization. If the managed care organization is unable to provide the department with a valid Kentucky address for the beneficiary within fourteen (14) business days, the department shall disenroll the individual from the Medicaid program;

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

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

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

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

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

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

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

4. The penalty for a violation of subsection (1)(e) of this section shall be

at least ten thousand dollars ($10,000) for each inactive provider included in an analysis of network adequacy; and

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

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

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

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

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

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

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

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

(f) Notwithstanding KRS 48.630, expenditures shall not be made from this

fund unless expressly appropriated by the General Assembly.

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

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

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

(1) ~~[By January 1, 2019,]~~A managed care organization shall ***maintain***~~[establish]~~ an interactive ***website***~~[Web site]~~, operated by the managed care organization, that allows providers to file grievances, appeals, and supporting documentation electronically in an encrypted format that complies with federal law and that allows a provider to review the current status of a matter relating to an appeal or a grievance filed concerning a submitted claim.

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

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

1. Behavioral health;

2. Physical health; and

3. Provider contract changes; and

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

1. Internal appeals; and

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

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

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

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

(a) Provide:

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

2. A toll-free telephone line for providers to submit requests for authorizations of covered services during normal business hours and extended hours in this state on Monday and Friday through 6 p.m., including federal holidays;

3. With regard to any adverse payment or coverage determination, copies of all documents, records, and other information relevant to a determination, including medical necessity criteria and any processes, strategies, or evidentiary standards relied upon, if requested by the provider. Documents, records, and other information required to be provided under this paragraph shall be provided at no cost to the provider; and

4. For any adverse payment or coverage determination, a written reply in sufficient detail to inform the provider of all reasons for the

determination. The written reply shall include information about the provider's right to request and receive at no cost to the provider documents, records, and other information under subparagraph 3. of this paragraph;

(b) Afford each participating provider the opportunity for an in-person meeting with a representative of the managed care organization on:

1. Any clean claim that remains unpaid in violation of KRS 304.17A-700 to 304.17A-730; and

2. Any claim that remains unpaid for forty-five (45) days or more after the date the claim is received by the managed care organization and that individually or in the aggregate exceeds two thousand five hundred dollars ($2,500);

(c) Reprocess claims that are incorrectly paid or denied in error, in compliance with KRS 304.17A-708. The reprocessing shall not require a provider to rebill or resubmit claims to obtain correct payment. ***A***~~[No]~~ claim shall ***not*** be denied for timely filing if the initial claim was timely submitted;~~[and]~~

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

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

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

b. Failure of the managed care organization to comply with

subdivision a. of this subparagraph shall result in:

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

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

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

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

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

(e) With regard to provider audits:

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

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

organization.

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

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

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

b. An explanation of the purpose of the audit;

c. The number of records being audited;

d. The timeframe covered by the records being audited;

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

f. The managed care organization's or, if the managed care organization has contracted with a third-party entity to conduct the audit, the third-party entity's point of contact for the audit, including the individual's name, telephone number, mailing address, email address, and fax number; and

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

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

a. A minimum of sixty (60) calendar days if more than thirty (30)

records are being requested or if the timeframe the records cover is more one (1) year; and

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

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

5. Complete an audit within one hundred eighty (180) calendar days from the date on which the written audit notification required under subparagraph 2. of this paragraph was sent to the provider;

6. Deliver written findings of a completed audit to the provider within thirty (30) calendar days of date on which the audit was completed. Written audit findings shall:

a. Include the name, phone number, mailing address, email address, and fax number of the managed care organization's or, if the managed care organization has contracted with a third-party entity to conduct the audit, the third-party entity's point of contact responsible for the audit findings;

b. Provide claims-level detail of the amounts and reasons for each claim recovery found to be due; and

c. Clearly state if no amounts have been found to be due;

7. a. Exempt, as provided in subparagraph 8. of this paragraph, a provider from recoupment of funds if an audit results in the identification of any clerical or recordkeeping errors, including typographical errors, scrivener's errors, omissions, or computer errors, unless the auditing entity provides proof of intent to commit fraud or the error results in an actual overpayment to the provider.

b. If an auditing entity discovers or is otherwise in possession of proof of intent to commit fraud, the auditing entity shall immediately notify the department;

8. Allow the provider to submit amended claims within thirty (30) calendar days of the discovery of a clerical or recordkeeping error in lieu of recoupment if the services were otherwise provided in accordance with state and federal law;

9. Not receive payment based on the amount recovered in the audit;

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

b. Reimburse the provider any recouped payments plus twenty-five percent (25%) interest on the recouped payments if:

i. The managed care organization recoups payments prior to the final disposition of the audit, including the appeals process as established in KRS 205.646; and

ii. The final disposition of the audit, including any appeal conducted in accordance with KRS 205.646, results in a finding in favor of the provider;

11. Base recoupment of claims on the actual overpayment or

underpayment of claims unless the provider agrees to a settlement to the contrary; and

12. When feasible, structure the recoupment of claims or demand for payment in a manner that does not cause a substantial reduction in cash flow for the provider.

(2) (a) For the purposes of this subsection:

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

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

i. The enrollee requests an extension; or

ii. The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and

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

i. The provider or enrollee requests an extension; or

ii. The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and

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

or regain maximum function.~~[; and]~~

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

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

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

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

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

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

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

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

5. Any other information required by the department.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) 1. Utilize a capitated payment model.

2. Capitation payments made to regional brokers shall be:

a. Actuarially sound;

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

c. Calculated based only on the number of nonemergency medical transportation service eligible Medicaid enrollees within a given region and shall not be based on the total number of Medicaid enrollees; and

(c) Require regional brokers to:

1. Achieve a medical loss ratio of at least ninety percent (90%) on capitation payments;

2. Provide a remittance to the state of any excess capitation payments for any medical loss ratio reporting period in which the regional broker fails to achieve a medical loss ratio of at least ninety percent (90%);

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

4. Collaborate with the Department for Medicaid Services, or another agency in state government or a private entity with which the department has contracted for the administration of a nonemergency medical transportation service program, to implement and execute a performance-based payment model that aligns incentives for Medicaid enrollees, drivers, regional brokers, and the Commonwealth to

improve quality, reliability, and cost-effectiveness in the nonemergency medical transportation service program. The value-based payment model required under this paragraph shall include a two percent (2%) withhold from each regional broker's capitation amount that can be earned back in full or in part by the regional transportation broker through the achievement of designated value-based measures which shall include but not be limited to:

a. Utilization rates;

b. The number of nonemergency medical transportation service trips completed;

c. The number of nonemergency medical transportation service trips cancelled or rescheduled;

d. The number of delayed nonemergency medical transportation service trips;

e. Average trip time;

f. Average miles per trip;

g. The amount of time required to schedule a nonemergency medical transportation service; and

h. Rider satisfaction.

(3) Utilization rates for nonemergency medical transportation services, including when calculated by an actuary under subsection (2) of this section, shall consider only nonemergency medical transportation service eligible Medicaid enrollees within a given region and shall not base utilization rates on the total number of Medicaid enrollees.

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

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

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

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

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

(a) Utilization rates;

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

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

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

(e) Average trip time;

(f) Average miles per trip;

(g) The amount of time required to schedule a nonemergency medical

transportation service;

(h) Rider satisfaction; and

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

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

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

(a) "Department":

1. Means the Department for Medicaid Services; and

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

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

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

(2) (a) The department shall not review or approve an incomplete Medicaid waiver program application, and any applicant who submits an incomplete waiver application shall not be placed on a waiver waitlist or enrolled in a waiver program. Before the department reviews a Medicaid waiver application, the application shall be fully completed by the applicant or an authorized representative of the applicant. A fully completed application shall include a primary diagnosis.

(b) The department shall not accept self-attestation for a primary diagnosis as

part of a waiver application and shall require documentation of the primary diagnosis from a licensed health care provider.

(3) (a) Beginning July 1, 2026, assessments conducted to determine level of care needs for enrollment in a waiver program shall be conducted solely by the applicant's licensed health care provider or a case manager, nurse, or social worker employed by or otherwise associated with the applicant's licensed health care provider.

(b) As part of an assessment conducted to determine level of care needs, a licensed health care provider shall assess social determinants of health and barriers to accessing care and assist the patient in accessing services, including but not limited to transportation, housing, and food security.

(c) In order to conduct level of care assessments for waiver programs, a licensed health care provider shall be certified by the Utilization Review Accreditation Commission, National Committee for Quality Assurance, or Commission on Accreditation of Rehabilitation Facilities.

(4) (a) Except as provided in paragraph (b) of this subsection, the department shall not require a separate or subsequent assessment, evaluation, or visit to determine medical eligibility for enrollment in a waiver program after an initial assessment conducted in accordance with subsection (3) of this section, unless such assessment is required under federal law.

(b) The cabinet shall:

1. Require or conduct ongoing maintenance efforts to determine continuation of waiver eligibility and to coordinate care through quarterly in-person visits with all individuals enrolled in a waiver program; and

2. Ensure adequate staffing to respond to the needs of waiver participants that may arise between quarterly in-person visits

performed in accordance with subparagraph 1. of this paragraph.

(5) A waiver program participant's case manager shall serve as the sole liaison to the department for ongoing patient follow-up care, care coordination, care plan updates, and prior authorization updates.

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

(7) (a) Except as provided in paragraphs (b) and (c) of this subsection, in order to be eligible for enrollment in a waiver program an individual shall be a citizen of the United States and have been a resident of the Commonwealth for at least three (3) years prior to enrollment.

(b) Notwithstanding paragraph (a) of this subsection, an individual who has been a resident of the Commonwealth for less than three (3) years may be enrolled in a waiver program for which there is no waitlist.

(c) This subsection shall not apply to individuals enrolled in a waiver program prior to the effective date of this Act.

(8) If an individual who is on a waiver program waitlist is enrolled in the Medicaid program or otherwise is receiving Medicaid state plan benefits, state plan benefits shall be provided to that individual on a fee-for-service basis and the individual shall not be enrolled with or assigned to a Medicaid managed care organization.

(9) (a) The cabinet shall reserve capacity in each waiver program to ensure availability of waiver slots for individuals determined to have an emergency need status and shall develop waitlist management policies for individuals seeking emergency placement in a waiver program.

(b) As used in this subsection, "emergency need status" means an individual who requires skilled nursing care.

(10) (a) For the purposes of identifying and eliminating waste, fraud, and abuse in

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

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

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

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

READ AS FOLLOWS:

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

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

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

2. Severity of physical or cognitive functional impairment;

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

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

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

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

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

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

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

(2) (a) Except as provided in paragraph (b) of this subsection, beginning January 1, 2027, access to waiver program services and the allocation of waiver slots within any waiver program for which there is a waitlist shall be based on an applicant's assigned priority level.

(b) This subsection shall not apply to the allocation of a waiver slot to an individual who was placed on the waitlist for the same 1915(c) waiver

program prior to the effective date of this Act.

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

1. The priority tier definitions and scoring criteria;

2. Applicant assessment and annual reassessment procedures; and

3. An appeals process for priority level determinations.

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

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

(1) The General Assembly finds and declares that:

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

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

(2) As used in this section:

(a) "Administrative service organization" or "ASO" means the entity

contracted by the department in accordance with subsection (3) of this section to perform specified administrative functions related to the administration of Medicaid-covered dental services without assuming a financial or insurance risk; and

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

(3) The department shall:

(a) No later than July 1, 2027, employ a full-time Medicaid dental director who shall report to the commissioner of the department and be responsible for overseeing the administration of Medicaid-covered dental services;

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

(c) In accordance with KRS Chapter 45A and subsection (5) of this section, select and contract with a third-party ASO to administer Medicaid-covered dental services. The contract entered into under this paragraph shall have an effective date of no later than January 1, 2028;

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

(e) No later than January 1, 2028:

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

2. Establish a Dental Services Advisory Panel which shall:

a. Include the following members:

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

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

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

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

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

(f) On January 1, 2028, begin utilizing an ASO delivery model for the administration of all Medicaid-covered dental services.

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

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

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

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

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

4. Providing coordination of care with a Medicaid beneficiary's

Medicaid managed care organization;

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

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

(c) 1. The total administrative fee or compensation paid to the ASO contracted with pursuant to this section shall not exceed two percent (2%) of the actual Medicaid-covered dental services claims paid by the ASO on an annual basis.

2. Notwithstanding subparagraph 1. of this paragraph, the department may establish an incentive payment program under which the ASO may earn additional compensation of up to one percent (1%) of the actual Medicaid-covered dental services claims paid by the ASO on an annual basis for improvements to network adequacy, service availability, and access to services as determined by the department.

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

(5) The contract entered into under this subsection shall be submitted to the Government Contract Review Committee of the Legislative Research Commission for comment and review.

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

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

1. Accuracy and timeliness of claims processing;

2. Efficiency of processing prior authorization requests;

3. Observed network adequacy improvements;

4. Availability of and access to services; and

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

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

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

(1) The General Assembly finds and declares that:

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

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

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

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

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

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

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

(b) No later than thirty (30) calendar days after the effective date of this Act, the director of the Commission shall provide the cabinet with a list of

databases, datasets, electronic records, and files determined by the director to be necessary for the meaningful and effective discharge of legislative duties, including oversight, policy making, and the appropriation of funds to provide for the administration of the Medicaid program by the General Assembly.

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

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

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

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

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

(4) The Commission and the cabinet may enter into a memorandum of

understanding governing the Commission's access to the shared databases, datasets, electronic records, and files. Any memorandum of understanding that may be entered into under this subsection:

(a) Shall not preclude or prohibit the Commission from providing information shared with the Commission under this section to any vendor or entity with which the Commission may contract for the purpose of analyzing, reviewing, studying, investigating, or evaluating the Medicaid program or any aspect thereof, including but not limited to any vendor with which the Commission may contract pursuant to Section 22 of this Act;

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

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

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

(6) In addition to the data-sharing requirements established in subsections (2), (3), (4), and (5) of this section, the cabinet shall provide the Commission with a copy of any reports or data that may be submitted to the cabinet by any vendor or entity

with which the cabinet has contracted for administration, examination, study, or review of any aspect of the Medicaid program.

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

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

(a) Leading health indicators;

(b) Performance indicators for Medicaid managed care organizations;

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

(d) Performance indicators for the department.

(2) The healthcare transparency dashboard shall be:

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

(b) Maintained and operated by the Commission.

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

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

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

(a) The cabinet;

(b) The department;

(c) Any other state agency;

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

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

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

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

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

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

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

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

(5) Recommend that the Auditor of Public Accounts perform a financial or special audit of the Medicaid program or any aspect thereof; and

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

➔SECTION 21. A NEW SECTION OF KRS CHAPTER 43 IS CREATED TO READ AS FOLLOWS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Identifying staffing inefficiencies or duplications;

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

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

(3) In each year in which the Auditor does not conduct a full and comprehensive examination as required under subsection (1) of this section, the Auditor shall conduct a review of the state's Medicaid program and the Kentucky Children's

Health Insurance Program for the purpose of assessing the Cabinet for Health and Family Services' progress in addressing any issues or recommendations that were identified in the most recent report prepared in accordance with subsection (5)(b) of this section.

(4) (a) The Office of Program Performance within the Commonwealth Office of the Ombudsman in the Auditor's office shall conduct all quality control reviews of the Department for Community Based Services within the Cabinet for Health and Family Services for Medicaid applications, Medicaid eligibility determinations, Supplemental Nutrition Assistance Program eligibility determinations, Temporary Assistance for Needy Families benefits, and Supplemental Nutrition Assistance Program benefit payment issuance allotments necessary to comply with federal law and regulations.

(b) The Cabinet for Health and Family Services shall provide the Office of Program Performance full access to all records, case files, data systems, personnel, and any other information necessary to complete quality control reviews.

(c) No other state agency shall perform quality control reviews of the Department for Community Based Services within the Cabinet for Health and Family Services for Medicaid applications, Medicaid eligibility determinations, Supplemental Nutrition Assistance Program eligibility determinations, Temporary Assistance for Needy Families benefits, and Supplemental Nutrition Assistance Program benefit payment issuance allotments unless otherwise authorized by the General Assembly.

(5) The Auditor shall:

(a) Submit an initial preliminary report of the results of each examination conducted in accordance with subsection (1) of this section to the

Legislative Research Commission for referral to the Interim Joint Committees on Appropriations and Revenue, Families and Children, and Health Services and the Medicaid Oversight and Advisory Board no later than December 1 of the year in which the examination is initiated;

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

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

2. Duplication of service or any other inefficiencies;

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

4. Waste, fraud, or abuse; and

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

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

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

(6) The cost of an examination conducted pursuant to subsection (1) of this section shall be borne by the Department for Medicaid Services, and the department shall

be required to take all necessary steps to access and drawdown any federal funds as may be available to support state efforts to ensure program integrity or audit activities.

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

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

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

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

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

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

(e) Beginning in 2026 and at least once every five (5) years thereafter, cause a review to be made of the administrative expenses and operational cost of the Medicaid program. The review shall include but not be limited to evaluating

the level and growth of administrative costs, the potential for legislative changes to reduce administrative costs, and administrative changes the department may make to reduce administrative costs or staffing needs. At the discretion of the ~~[Legislative Research]~~Commission, the review may be conducted by a consultant retained by the board;

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

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

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

(i) Beginning in 2026 and annually thereafter, publish a report covering the

board's evaluations and recommendations with respect to the Medicaid program. The report shall be submitted to the ~~[Legislative Research]~~Commission no later than December 1 of each year, and shall include at a minimum a summary of the board's current evaluation of the program and any legislative recommendations made by the board.

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

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

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

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

(3) At the discretion of the ~~[Legislative Research]~~Commission**:**~~[,]~~

(a) An examination of the Medicaid program conducted by the Auditor of

Public Accounts under Section 21 of this Act may constitute fulfillment of the board's duties established in subsection (1)(e) and (f) of this section; and

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

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

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

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

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

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

(a) For any introduced legislation or filed amendment:

1. The sponsor of the legislation or amendment;

2. The President of the Senate, if the Senate is in possession of the

legislation;

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

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

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

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

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

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

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

2. Expenditures, including:

a. Expenditures of state general fund moneys, restricted funds, and federal medical assistance or federal Medicaid matching funds; and

b. Any potential cost savings, including but not limited to any cost savings that may result from changes in utilization rates, administrative efficiencies, or improved health of the Medicaid population;

3. a. Capitation rates paid to Medicaid managed care organizations contracted by the Department for Medicaid Services; and

b. Reimbursement rates for Medicaid-covered services delivered on a fee-for-service basis; and

4. Beneficiary enrollment in the Medicaid program including, if applicable, any 1915(c) home and community-based waiver program administered by the Department for Medicaid Services;

(b) Be produced by an economic consulting firm retained by the Legislative Research Commission;

(c) Be provided in a uniform format established by the Legislative Research Commission; and

(d) Include a certification that the information contained in the impact statement is complete and accurate.

(5) The economic consulting firm retained by the Legislative Research Commission for Medicaid impact statements shall:

(a) Have significant experience in analyzing the fiscal and economic impact of Medicaid-related program changes; and

(b) Have the capacity to complete requested Medicaid impact statements within seven (7) business days.

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

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

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

and comment; and

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

➔Section 25. The following KRS sections are repealed:

205.515 Medicaid program delivery system.

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

➔Section 26. There is hereby appropriated General Fund moneys from the Budget Reserve Trust Fund Account established by KRS 48.705 in the amount of $500,000 in fiscal year 2025-2026 to the Auditor of Public Accounts budget unit to fulfill staffing and technology needs related to Section 21 of this Act. Notwithstanding KRS 45.229, these funds shall not lapse and shall carry forward.

➔Section 27. (1) The Medicaid Oversight and Advisory Board established in KRS 7A.273 is hereby directed to establish a Dental Services Transition Subcommittee to oversee the implementation of Section 17 of this Act and the transitioning of Medicaid-covered dental service from a managed care delivery model to an administrative services organization delivery model.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Be dissolved on December 1, 2028.

➔Section 28. Any contract between the Department for Medicaid Services and a Medicaid managed care organization entered into, renewed, or extended after the effective date of this Act but prior to January 1, 2028, shall include notice to the managed care organization of the department's intent to transition to an administrative service organization delivery model for Medicaid-covered dental services effective January 1, 2028.

➔Section 29. If the Cabinet for Health and Family Services or the Department for Medicaid Services determines that a state plan amendment, waiver, or any other form of

authorization or approval from any federal agency to implement Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, or 17 of this Act is necessary to prevent the loss of federal funds or to comply with federal law, the cabinet or department:

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

(2) May only delay implementation of the provisions of Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, and 17 of this Act for which federal authorization or approval was deemed necessary until the federal authorization or approval is granted.

➔Section 30. Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, and 29 of this Act shall constitute the specific authorization required under KRS 205.5372(1).

➔Section 31. The Medicaid Oversight and Advisory Board, established in KRS 7A.273, is hereby directed to evaluate the Medicaid nonemergency medical transportation, or NEMT, program during the 2026 Legislative Interim. As part of the evaluation directed by this section the board shall:

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

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

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

(b) The regional broker system; and

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

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

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

(5) Identify strategies to:

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

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

(c) Improve customer satisfaction; and

(d) Enhance administrative efficiencies; and

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

➔Section 32. Provisions of Section 31 of this Act to the contrary notwithstanding, the Legislative Research Commission shall have the authority to alternatively assign the issues identified therein to an inter joint committee or subcommittee thereof, and to designate a study completion date.

➔Section 33. Sections 31 and 32 of this Act shall have the same legal status as a House Concurrent Resolution.

➔Section 34. Whereas recently enacted federal changes to the Medicaid program and significant increases in the Commonwealth's Medicaid budget over the last decade create an urgent need to bolster legislative oversight of the Medicaid program, take immediate steps to comply with new federal requirements, and ensure that Medicaid expenditures support the healthcare needs of only those individuals the program is intended to serve, an emergency is declared to exist, and this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming a law.