AN ACT relating to the Kentucky statewide health data utility.

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

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

***(1) The Kentucky statewide health data utility is established in Sections 1 to 10 of this Act to effectuate the following purposes:***

***(a) Create a seamless, transparent, and secure approach to health information sharing and exchange among broad health care and health care coordination settings that:***

***1. Uses health information technology to support health-related functions, including without limitation:***

***a. A patient's health care experience;***

***b. The overall health of the population; and***

***c. Health care quality and value;***

***2. Improves patient outcomes and the overall health and well-being of Kentucky residents by:***

***a. Creating administrative efficiencies in health care delivery; and***

***b. Preventing health care errors;***

***3. Identifies opportunities for savings while improving health outcomes;***

***4. Informs state health care planning;***

***5. Improves the accessibility, adequacy, and affordability of health care and health coverage through the review and dissemination of data;***

***6. Evaluates the effectiveness of health care programs and services to improve patient outcomes; and***

***7. Supports the development of quality improvement initiatives;***

***(b) Operate and govern a statewide health data utility that:***

***1. Represents the interests and meets the needs of:***

***a. Patients;***

***b. The health care sector; and***

***c. The General Assembly;***

***2. Ensures the integrity, privacy, and security of personal health information and other proprietary information related to the collection and release of data;***

***3. Promotes best practices for health information sharing and exchange;***

***4. Provides data to authorized recipients, as allowed by law; and***

***5. Makes meaningful and relevant information available to the public;***

***(c) Ensure the creation of clear data governance, privacy, and security policies to facilitate the sharing and exchange of health information through the statewide health data utility;***

***(d) Demonstrate a commitment to respecting personal privacy by establishing protocols and standards that:***

***1. Ensure compliance with all applicable state and federal data privacy and security laws relating to the collection, storage, and release of data; and***

***2. Allow an opt-out for patients who choose not to share their personal data;***

***(e) Promote a policy of health information sharing and exchange that follows the patient and improves the health of Kentucky residents; and***

***(f) Establish a duty for health care professionals, health facilities, health care payers, and other persons that deliver, administer, or coordinate health care to share and exchange information for the purpose of optimizing patient and population health, as allowed by law.***

***(2) Sections 1 to 10 of this Act shall not be construed to create a health benefit network or other type of health insurance network.***

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

***As used in Sections 1 to 10 of this Act:***

***(1) "Authorized recipient" means any of the following:***

***(a) The General Assembly, the Legislative Research Commission, or a committee, task force, or other body established by the General Assembly or Legislative Research Commission;***

***(b) Health care professionals;***

***(c) Health facilities;***

***(d) Health care payers;***

***(e) Health care purchasers;***

***(f) Patients;***

***(g) The executive director; and***

***(h) Members of academia engaged in health-related research;***

***(2) "Board" means the Kentucky Health Information Technology Board established in Section 7 of this Act;***

***(3) "Consortium of public health colleges" or "consortium" means the consortium created in Section 6 of this Act to operate and govern the Kentucky statewide health data utility;***

***(4) "Electronic longitudinal health record" means an electronic collection of health information about the health status of an individual that:***

***(a) Is compiled over time;***

***(b) May be derived from multiple sources; and***

***(c) Includes the individual's:***

***1. Clinical data;***

***2. Health care claims data;***

***3. Social referrals; and***

***4. Designated public health data, including but not limited to immunizations and laboratory data;***

***(5) "Executive director" means the executive director of the Office of Data Analytics created in Section 12 of this Act;***

***(6) "Federally-qualified health center" has the same meaning as in 42 U.S.C. sec. 1396d, as amended;***

***(7) "Health care claims data" means data relating to claims made for the payment or reimbursement of the following types of health care services:***

***(a) Medical and hospital, which includes without limitation surgical, mental health, substance use disorder, nursing, habilitative and rehabilitative, and laboratory;***

***(b) Dental;***

***(c) Pharmacy; and***

***(d) Any other health care services designated by the executive director by administrative regulation promulgated in accordance with KRS Chapter 13A;***

***(8) "Health care payer" means any of the following, to the extent the person, plan, or program makes payments or reimbursements for, or administers the payment or reimbursement of, health care services:***

***(a) Medicare;***

***(b) Medicaid;***

***(c) The Kentucky Children's Health Insurance Program;***

***(d) Any state or local government health plan or program regulated, created, or authorized under Kentucky law, including without limitation:***

***1. Any plan or program offered or administered under KRS Chapter 205; and***

***2. Any governmental plan, as defined in 29 U.S.C. sec. 1002, including***

***any plan offered to the Public Employee Health Insurance Program for public employees under KRS 18A.225 or 18A.2254;***

***(e) Any federal health plan or program that provides coverage in Kentucky for health care services;***

***(f) Any insurers or administrators offering or administering a plan or program identified in paragraph (d) or (e) of this subsection;***

***(g) Any federal, state, or local government cabinet, agency, department, entity, or official that provides, or contracts with a third-party administrator to administer, a plan or program identified in paragraph (d) or (e) of this subsection;***

***(h) Workers' compensation insurers, including governmental and nongovernmental workers' compensation self-insurers and self-insured groups;***

***(i) Insurers, self-insurers, and self-insured groups, including governmental and nongovernmental self-insured employers, self-insured health plans, and self-insured employer-organized associations, that provide:***

***1. Coverage for health care services;***

***2. Health care benefits; or***

***3. Any kind of insurance regulated under KRS Chapter 304;***

***(j) Health maintenance organizations;***

***(k) Limited health service organizations;***

***(l) Provider-sponsored integrated health delivery networks;***

***(m) Nonprofit hospital, medical-surgical, dental, and health service corporations;***

***(n) Administrators, as defined in KRS 304.9-051;***

***(o) Pharmacy benefit managers;***

***(p) Any other third-party payor that is subject to regulation under the insurance***

***laws of this state; and***

***(g) Any vendor or contractor of a person, plan, or program listed in this subsection;***

***(9) "Health care professional":***

***(a) Means any individual who is licensed, certified, or otherwise authorized under the laws of this state to administer or provide health care services in the:***

***1. Ordinary course of business; or***

***2. Practice of a profession; and***

***(b) Includes:***

***1. Pharmacists; and***

***2. Home medical equipment and services providers;***

***(10) "Health care purchaser":***

***(a) Means an entity that purchases, or arranges the purchase of, coverage for health care services or health care benefits for a defined population; and***

***(b) Includes without limitation employers, labor unions, associations, and governmental health benefit programs;***

***(11) "Health facility":***

***(a) Has the same meaning as in KRS 216B.015; and***

***(b) Includes a:***

***1. Pharmacy;***

***2. Medical laboratory;***

***3. Facility that provide habilitative and rehabilitative services, including without limitation physical, occupational, and speech therapy services;***

***4. Federally-qualified health center; and***

***5. Public health agency;***

***(12) "Health information":***

***(a) Means any information, including genetic information, whether oral or recorded in any form or medium, that:***

***1. Is created or received by a participant; and***

***2. Relates to the:***

***a. Past, present, or future physical or mental health or condition of an individual;***

***b. Provision of health care to an individual; or***

***c. Past, present, or future payment or reimbursement for the provision of health care to an individual; and***

***(b) Includes the following:***

***1. Health information as defined in 45 C.F.R. sec. 160.103, as amended, that is created or received by a participant;***

***2. Health care claims data; and***

***3. Actions taken by a participant in the participant's capacity as a public health authority under HIPAA or as required or permitted under other federal or state law relating to public health activities;***

***(13) "Health information technology":***

***(a) Means the application of information processing, involving computer hardware and software, to electronically store, retrieve, share, and use health information; and***

***(b) Includes the creation of the following electronic records, functions, and tools:***

***1. Electronic longitudinal health records;***

***2. Personal health records through which an individual or any other person authorized by the individual can maintain and manage the individual's health information;***

***3. Health records that are:***

***a. Used by health care professionals to electronically document, monitor, and manage health care delivery within a care delivery organization;***

***b. The legal record of a patient's encounter with the care delivery organization; and***

***c. Owned by the care delivery organization;***

***4. Diagnostic and treatment services records, including records of the prescribing and dispensing of medication;***

***5. Decision support functions to assist health care professionals in making clinical decisions by providing electronic alerts and reminders to:***

***a. Improve compliance with best practices;***

***b. Promote regular screenings; or***

***c. Promote other preventive practices to facilitate diagnosis and treatments; and***

***6. Tools to allow for the collection, analysis, and reporting of information or data on:***

***a. Adverse health events;***

***b. The quality and efficiency of health care;***

***c. Patient satisfaction; and***

***d. Other performance measures related to health care;***

***(14) "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended, and any related federal regulations, as amended;***

***(15) "Interoperability":***

***(a) Means the ability of two (2) or more persons, systems, or components to exchange, and use exchanged, information or data in an accurate, effective,***

***secure, and consistent manner; and***

***(b) Includes without limitation the:***

***1. Capacity to connect to a network for the purpose of exchanging information or data with other users;***

***2. Ability of a connected, authenticated user to demonstrate appropriate permissions to participate in an instant transaction over a network; and***

***3. Capacity of a connected, authenticated user to access, transmit, receive, and exchange usable information with other users;***

***(16) "Kentucky statewide health data utility" or "statewide health data utility" means the statewide health data utility established in Sections 1 to 10 of this Act;***

***(17) "Participant" means any of the following:***

***(a) A health facility;***

***(b) A health care payer;***

***(c) An entity engaged in the sharing of community information or social determinants of health; and***

***(d) A person that is not required under state or federal law to comply with Section 8 of this Act, but otherwise elects to submit health information to the Kentucky statewide health data utility;***

***(18) "Person" includes:***

***(a) A natural person;***

***(b) Any type or form of corporation, company, partnership, proprietorship, association, plan, program, or other legal entity; and***

***(c) A government, governmental subdivision or agency, or other body politic; and***

***(19) "Public health agency" means an entity that is governed by or contractually responsible to a local health department, the cabinet, or a state agency to provide***

***services focused on the health status of population groups and their environments.***

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

***(1) The Kentucky statewide health data utility fund is hereby established as a restricted fund in the State Treasury.***

***(2) The following shall be deposited into the fund:***

***(a) All grants, gifts, and funds received or raised under Section 4 of this Act;***

***(b) Any fees charged to authorized recipients for access to data in the statewide health data utility;***

***(c) Any penalties collected under Section 9 of this Act; and***

***(d) Any appropriations made to the fund by the General Assembly.***

***(3) Notwithstanding KRS 45.229, moneys in the fund not expended at the close of a fiscal year shall not lapse but shall be carried forward to the next fiscal year.***

***(4) Moneys in the fund shall be available to the executive director, who may use or direct the use of the moneys in the development, implementation, operation, and maintenance of the Kentucky statewide health data utility.***

➔SECTION 4. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

***(1) The executive director shall be responsible for the development, implementation, operation, and maintenance of the Kentucky statewide health data utility in accordance with Sections 1 to 10 of this Act.***

***(2) In carrying out the duties in subsection (1) of this section, the executive director:***

***(a) Shall make good-faith efforts to:***

***1. Seek and accept grants or gifts, or raise funds, from any available source, public or private, to support the development, implementation, operation, and maintenance of the statewide health data utility; and***

***2. Establish agreements:***

***a. For voluntary reporting of health information from participants that are not subject to the mandatory reporting requirements under Section 8 of this Act; and***

***b. With the federal Centers for Medicare and Medicaid Services to obtain Medicare health care claims data and other health information;***

***(b) 1. Subject to subparagraph 2. of this paragraph, may establish the following:***

***a. Agreements with health data utilities in other states, including all-payer claims databases, to establish a single application for access to data by authorized recipients across multiple states; and***

***b. Agreements with state and federal agencies and other health data utilities and health databases to share and receive health information or other data, including confidential and proprietary information or data, if:***

***i. The recipient agrees in a written or electronic record to maintain any confidential or proprietary status afforded to the information or data; and***

***ii. The information or data is shared or received in a manner that does not violate any applicable laws.***

***2. Prior to establishing an agreement authorized under subparagraph 1. of this paragraph, the executive director shall:***

***a. Submit a draft of the proposed agreement to the board;***

***b. Provide the board not less than thirty (30) days to review, and advise the executive director on, the proposed agreement***

***submitted under subdivision a. of this subparagraph; and***

***c. Determine, after review and comment from the board, that the agreement:***

***i. Is consistent with the policies and procedures adopted by the board under subsection (1)(a) of Section 7 of this Act; and***

***ii. Supports the purposes set forth in Section 1 of this Act;***

***(c) Shall:***

***1. Within one hundred eighty (180) days after the effective date of the consortium's organizing documents, contract with the consortium of public health colleges to operate and govern the statewide health data utility in accordance with Sections 1 to 10 of this Act;***

***2. Submit the contract entered into with the consortium under subparagraph 1. of this paragraph to the Government Contract Review Committee for review pursuant to KRS 45A.705; and***

***3. Enforce and ensure compliance with the contract entered into with the consortium under this paragraph;***

***(d) Shall monitor, and provide input and oversight to the consortium in, the operation and governance of the statewide health data utility;***

***(e) Shall ensure the statewide health data utility is operated in compliance with all state and federal law, including without limitation:***

***1. HIPAA; and***

***2. 42 U.S.C. sec. 290dd-2, as amended, and any related federal regulations, as amended, including without limitation 42 C.F.R. pt. 2;***

***(f) Subject to subsection (3) of this section, shall promulgate administrative regulations in accordance with KRS Chapter 13A to establish policies and procedures necessary for the administration, operation, and oversight of the***

***statewide health data utility, which shall include:***

***1. a. Subject to subdivision b. of this subparagraph:***

***i. Health information sharing and submission requirements for participants; and***

***ii. The reporting format, and frequency of submissions, for health information submitted by participants to the consortium of public health colleges.***

***b. The requirements established under this subparagraph shall comply with:***

***i. Interoperability guidance published by the federal Centers for Medicare and Medicaid Services;***

***ii. Policies and procedures adopted by the board under subsection (1)(a) of Section 7 of this Act; and***

***iii. All applicable federal and state data privacy and security laws, including without limitation HIPAA;***

***2. Subject to Section 9 of the Act, the schedule of penalties for any participant that fails to comply with the mandatory reporting requirements under Section 8 of this Act;***

***3. a. Subject to subdivisions b. and c. of this subparagraph, the data elements that will be available to authorized recipients and the public.***

***b. Data shall not be made available to an authorized recipient or the public unless the data:***

***i. Complies with all applicable federal and state data privacy and security laws, including without limitation HIPAA; and***

***ii. Cannot be used to identify an individual, unless identifying***

***information about an individual is otherwise required to carry out a purpose set forth in subsection (2)(b)2.b. or c. of Section 5 of this Act.***

***c. The Legislative Research Commission shall, for the purpose of collecting and analyzing data to inform public policy as to health care access, utilization, cost, safety, and quality in Kentucky, be provided direct, read-only access to data contained in the statewide health data utility that:***

***i. Complies with all applicable federal and state data privacy and security laws, including without limitation HIPAA; and***

***ii. Cannot be used to identify an individual; and***

***4. Any fees that may be charged to authorized recipients for access to data in the statewide health data utility, except that a fee or cost of any kind shall not be charged to or required of the General Assembly, the Legislative Research Commission, or a committee, task force, or other body established by the General Assembly or Legislative Research Commission for those entities to access, receive, or use data contained in the statewide health data utility; and***

***(g) May contract with one (1) or more vendors or contractors for any expertise, service, or function that is necessary to assist the executive director in carrying out the executive director's duties under Sections 1 to 10 of this Act.***

***(3) (a) Prior to making a filing under KRS Chapter 13A, the executive director shall:***

***1. Submit drafts of any new, amended, or repealer emergency or ordinary administrative regulation, along with any forms required***

***under KRS 13A.230, required or authorized under Sections 1 to 10 of this Act or otherwise related to the statewide health data utility, to the board; and***

***2. Provide the board not less than thirty (30) days to review, and advise the executive director on, the drafts submitted under subparagraph 1. of this paragraph.***

***(b) In addition to the requirements of paragraph (a) of this subsection, the executive director and the consortium of public health colleges shall keep the board informed about, and consult with the board regarding, the development, implementation, operation, and maintenance of the statewide health data utility.***

➔SECTION 5. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

***(1) As used in this section:***

***(a) "All-payer claims database" means a database that systematically collects health care claims data from health care payers;***

***(b) "Community information exchange":***

***1. Means an ecosystem comprised of multidisciplinary network partners that use standardized technical language, a resource database, and an integrated technology platform to deliver:***

***a. Enhanced community care planning; and***

***b. Tools to enable partners to integrate data from multiple sources and make bi-directional referrals to create shared longitudinal records; and***

***2. Includes any system that:***

***a. Stores an individual's personal identifiable information in a database that is shared by a network of one (1) or more health***

***facilities, health care professionals, health care payers, public agencies, or community-based organizations for referral purposes; and***

***b. Encompasses data sets containing personal referral information captured and stored in a database for use by public and private entities, including community-based organizations, to provide services, update referral activity, and close the loop on a referral by updating downstream systems;***

***(c) "Health care information exchange" means the movement and exchange among and between health facilities and health care professionals of health information electronically across organizations within a state, region, community, or hospital system; and***

***(d) "Prescription information exchange" means the movement and exchange among and between health facilities and health care professionals of health information consisting of all medications dispensed by a pharmacy and other related information electronically across organizations within a state, region, community, or hospital system.***

***(2) The Kentucky statewide health data utility shall:***

***(a) Be the sole statewide network for the sharing and exchange of health information;***

***(b) Utilize health information technology to:***

***1. Aggregate health information received from participants;***

***2. Provide access, in a form and manner that ensures the privacy and security of personal health information as required under federal and state law, including without limitation HIPAA, to health information in the statewide health data utility to authorized recipients for the purposes of:***

***a. Collecting and analyzing data to inform the authorized recipients as to health care access, utilization, cost, safety, and quality in Kentucky;***

***b. Enabling any health care professional or health facility to evaluate and monitor care and treatment of patients; and***

***c. Enabling any patient to access, through a technology enabled interface, the patient's electronic longitudinal health record; and***

***3. Make information about health care services available to the public in a manner that allows consumers to draw meaningful comparisons between health facilities, health care payers, and other health care professionals as relevant data is available; and***

***(c) Contain the following:***

***1. A health care information exchange;***

***2. A pharmacy information exchange;***

***3. An all-payer claims database;***

***4. A community information exchange; and***

***5. Other referential sources, including without limitation public health data and self-generated data.***

***(3) (a) The information and data acquired by or contained in the statewide health data utility shall not be subject to disclosure under KRS 61.870 to 61.884.***

***(b) This subsection shall not be construed to limit or prohibit the public release of aggregated, deidentified information, reports, analyses, or dashboards by the statewide health data utility in accordance with Sections 1 to 10 of this Act.***

➔SECTION 6. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

***(1) (a) There is hereby established a consortium between the:***

***1. University of Kentucky College of Public Health;***

***2. University of Louisville School of Public Health and Information Services;***

***3. Eastern Kentucky University College of Health Sciences; and***

***4. Western Kentucky University Department of Public Health.***

***(b) Within sixty (60) days after the effective date of this Act, the consortium shall adopt organizing documents that provide for:***

***1. A governing board to govern the consortium, consisting of representatives from each member of the consortium in equal proportion;***

***2. The appointment of a director by the governing board to manage the consortium's daily operations; and***

***3. The delegation of such powers and responsibilities to the director as may be necessary for the consortium's efficient operation.***

***(2) (a) Within one hundred eighty (180) days after the effective date of the consortium's organizing documents, the consortium shall enter into a contract with the executive director to operate and govern the Kentucky statewide health data utility in accordance with Sections 1 to 10 of this Act.***

***(b) The consortium shall:***

***1. Not release, publish, or otherwise use any health information, records, or data to which the consortium, or any vendor or contractor of the consortium, has access to under Sections 1 to 10 of this Act without express authorization in a written or electronic record from the executive director; and***

***2. Monitor and supervise any vendor or contractor of the consortium to ensure that the vendor or contractor complies with Sections 1 to 10 of this Act.***

***(3) In operating and governing the statewide health data utility, the consortium shall:***

***(a) Ensure that the statewide health data utility:***

***1. Is value-driven and responsive to the needs of health care, public health, and community stakeholders;***

***2. Provides a variety of services from which to choose to best fit the needs of authorized recipients;***

***3. a. Complies with established national standards regarding data accuracy and quality that shall include periodically conducting, or contracting to conduct, audits of health information submitted to the statewide health data utility to corroborate:***

***i. Compliance with Section 8 of this Act; and***

***ii. The accuracy, completeness, and timeliness of the information.***

***b. Any audits conducted under this subparagraph shall, to the extent practicable, be coordinated with other audits or examinations performed by other state or federal agencies or health utilities or databases;***

***4. Protects the:***

***a. Privacy of patients; and***

***b. Security and confidentiality of health information;***

***5. Facilitates and supports the secure, electronic exchange of health information;***

***6. Promotes interoperability;***

***7. Provides a mechanism for participants without electronic health information to provide health information to the statewide health data utility;***

***8. Has a disaster recovery mechanism that allows access to health information in the event of a disaster, a use of ransomware, a cyberattack, or another emergency scenario;***

***9. Increases the accuracy, completeness, and uniformity of health information;***

***10. Allows a patient to opt out from including the patient's electronic longitudinal health record in the statewide health data utility, except an opt-out under this subparagraph shall not prevent the statewide health data utility from including the patient's deidentified or aggregated health care claims data or encounter data for the purpose of population health monitoring, public health reporting, academic research, or policy analysis, if the data cannot reasonably be used to reidentify the patient; and***

***11. Provides education to the general public and the health care sector about the value and benefits of a statewide health data utility;***

***(b) Operate the statewide health data utility:***

***1. Efficiently and effectively, using sound business and data governance practices consistent with the goals of:***

***a. Public accountability;***

***b. Transparency; and***

***c. Improving health outcomes; and***

***2. Independently in its technical and analytic functions;***

***(c) Report to the executive director and secretary any finding made, or information received, by the consortium that:***

***1. Relates to a person who is required to comply with Section 8 of this Act; and***

***2. Indicates that the person referenced in subparagraph 1. of this***

***paragraph has, or may have, materially failed or willfully refused to comply with Section 8 of this Act;***

***(d) Ensure that health information is accessible to authorized recipients and the public in a manner that:***

***1. For health information that is provided for the purpose of collecting and analyzing data, allows for comparisons of:***

***a. Geographic, demographic, and economic factors; and***

***b. Institutional size; and***

***2. For health information that is provided to patients and the public, is consumer friendly;***

***(e) For data that is made available to authorized recipients and the public, establish a process for requesting and accessing the data that:***

***1. Complies with subsection (2)(f)3. and 4. of Section 4 of this Act; and***

***2. May include requiring authorized recipients to enter into additional data service agreements or memoranda of understanding prior to accessing or using health information in the statewide health data utility;***

***(f) Prohibit any person, including an authorized recipient, from accessing or using health information in the statewide health data utility for any of the following purposes:***

***1. To obtain or disclose trade secrets;***

***2. To reidentify or attempt to reidentify an individual's data or information;***

***3. To distribute the data or information for a commercial purpose;***

***4. To take any action in violation of applicable data privacy or security laws; or***

***5. For any purpose not identified in subsection (2)(b)2. or 3. of Section 5***

***of this Act;***

***(g) Require all authorized recipients and the public to agree in a written or electronic record to comply with paragraph (f) of this subsection prior to accessing or using health information in the statewide health data utility;***

***(h) 1. Conduct a risk assessment and prepare a mitigation remediation plan in the form of a privacy impact assessment, which shall be submitted to and approved by the board.***

***2. The assessment and plan shall:***

***a. Assess risks to an individual's right to privacy within the statewide health data utility where the individual does not possess immediate control over the individual's information;***

***b. Recommend alternatives to both mitigate the risks and achieve the stated objectives of the statewide health data utility; and***

***c. Identify those individuals within the consortium who shall be directly accountable for:***

***i. The assessment and plan;***

***ii. The statewide health data utility at the time the assessment and plan are conducted and prepared; and***

***iii. The implementation of any approved alternatives and mitigations as a result of the assessment and plan; and***

***(i) Administer data governance and HIPAA training to all members of the board within sixty (60) days of each member's appointment.***

➔SECTION 7. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

***(1) There is hereby established the Kentucky Health Information Technology Board, whose duties shall be to:***

***(a) Establish policies and procedures for the sharing of health information by***

***participants under Sections 1 to 10 of this Act, including the submission of health information by participants to the consortium of public health colleges;***

***(b) Actively promote improved health data utility governance practices across the state;***

***(c) Identify and approve pivotal health data utility governance roles and responsibilities between government agencies and the private sector, as permitted by applicable federal and state law;***

***(d) Advise on, review, and approve the consortium's data control, governance, and privacy practices in compliance with federal and state information privacy and security policies and laws;***

***(e) Drive strategic and timely implementation of the consortium's privacy policies, related procedures, and processes to operationalize policy-driven controls and effective risk management methodologies, using industry standards;***

***(f) Review and approve the risk assessment and mitigation remediation plan conducted and prepared by the consortium under Section 6 of this Act; and***

***(g) Advise on, review, and make recommendations for:***

***1. The data elements that will be available to authorized recipients and the public, including specific strategies for ensuring the accessibility of data related to health care access, utilization, cost, safety, and quality;***

***2. The process for authorized recipients to access and request data; and***

***3. Any other matters submitted to the board relating to the development, implementation, operation, and maintenance of the statewide health data utility.***

***(2) (a) The board shall consist of the following members:***

***1. One (1) individual who has experience in pharmacy informatics;***

***2. One (1) member of academia with experience in health care data research;***

***3. One (1) hospital administrator who is appointed from a list of at least three (3) candidates submitted by the Kentucky Hospital Association;***

***4. One (1) representative from the Kentucky Hospital Association;***

***5. One (1) representative from the Kentucky Medical Association;***

***6. One (1) representative from the Kentucky Pharmacists Association;***

***7. One (1) representative from the Kentucky Dental Association;***

***8. One (1) representative from the Kentucky Primary Care Association;***

***9. One (1) representative of a Medicaid managed care organization or an organization that represents Medicaid managed care organizations;***

***10. One (1) representative of a commercial health care payer or an organization that represents health insurers;***

***11. One (1) representative of a health care purchaser or an organization that represents health care purchasers;***

***12. One (1) representative of:***

***a. A property and casualty insurer;***

***b. A workers' compensation insurer; or***

***c. An organization that represents property and casualty or workers' compensation insurers;***

***13. One (1) individual representing health care consumers; and***

***14. One (1) privacy officer of a health care payer, health care purchaser, or health facility;***

***(b) In addition to the members listed in paragraph (a) of this subsection:***

***1. The following persons, or their designees, shall serve as voting ex officio members of the board:***

***a. The commissioner of the Department of Insurance;***

***b. The executive director of the Commonwealth Office of Technology;***

***c. The commissioner of the Department of Employee Insurance; and***

***d. The Attorney General;***

***2. The following persons, or their designees, shall serve as nonvoting ex officio members:***

***a. A member of the House of Representatives, who shall be appointed by the Speaker of the House of Representatives;***

***b. A member of the Senate, who shall be appointed by the President of the Senate;***

***c. The commissioner of the Department for Medicaid Services;***

***d. The commissioner of the Department for Public Health;***

***e. The commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities; and***

***f. The director of the consortium of public health colleges; and***

***3. The executive director shall serve as chair of the board, but shall not have a vote unless there is a tie, in which case the executive director may cast the deciding vote.***

***(c) The members listed in paragraph (a) of this of this subsection:***

***1. Shall be appointed by the secretary;***

***2. Shall serve a term of four (4) years; and***

***3. May be reappointed.***

***(d) 1. The secretary shall fill all vacancies under paragraph (a) of this subsection within sixty (60) days of the vacancy.***

***2. In the event a representative or person listed in paragraph (a) of this***

***subsection is not available or willing to serve, the secretary shall appoint a person with expertise or experience in the applicable referenced industry or subject matter.***

***(e) Within sixty (60) days of appointment, each board member shall complete the data governance and HIPAA training administered by the consortium.***

***(3) The policies and procedures adopted by the board for the sharing and submission of health information by participants under Sections 1 to 10 of this Act shall:***

***(a) Set forth:***

***1. The data elements to be shared and submitted by participants to the consortium, which shall include without limitation the information that shall be included in the clinical data captured by participants in their existing electronic health records;***

***2. The reporting format for the sharing and submission of health information, which:***

***a. May vary based on the type of data reported; and***

***b. If feasible, shall adopt the reporting format for self-insured group health plans described in 29 U.S.C. sec. 1191d, as amended, for the reporting of health care claims data; and***

***3. The frequency of submissions; and***

***(b) Comply with:***

***1. Interoperability guidance published by the federal Centers for Medicare and Medicaid Services; and***

***2. All applicable federal and state data privacy and security laws, including without limitation HIPAA.***

***(4) The board may seek information from any person if the board deems that the information is relevant to better inform the board of its duties.***

***(5) The first meeting of the board shall be held within thirty (30) days after***

***appointment of all of the members.***

***(6) (a) The board shall meet upon the call of the chair, but not less than quarterly for the first two (2) years after the date of the first board meeting. Thereafter, the board shall meet not less than semiannually.***

***(b) A majority of the voting members, which includes the chair, shall constitute a quorum to do business.***

***(c) Actions of the board shall require a:***

***1. Quorum; and***

***2. Majority of the voting members present.***

***(d) A member shall be permitted to participate and vote in board business through distance communication technology.***

***(7) The board shall be a budget unit of the cabinet, which shall:***

***(a) Pay the board's necessary operating expenses; and***

***(b) Furnish all office space, personnel, equipment, supplies, and technical or administrative services required by the board in the performance of the functions established in this section.***

***(8) Members of the board, other than cabinet employees, shall not receive compensation from the cabinet for the member's service on the board, but shall receive actual and necessary travel expenses associated with attending meetings in accordance with state administrative regulations relating to travel reimbursement.***

➔SECTION 8. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

***(1) To the extent permitted under federal law:***

***(a) A participant shall comply with all health information sharing and submission requirements established for the participant by the executive director in administrative regulations promulgated in accordance with***

***Section 4 of this Act; and***

***(b) Any person not required to comply with paragraph (a) of this subsection under state or federal law may elect to voluntarily submit health information to the Kentucky statewide health data utility.***

***(2) A person that is required to comply with subsection (1)(a) of this section shall enter into an agreement with the consortium to submit health information to the statewide health data utility not later than the last of the following to occur:***

***(a) Three (3) months after the relevant exchange or database within the statewide health data utility becomes operational; or***

***(b) The date the person begins to do business, operate, or otherwise engage in activity that requires compliance with subsection (1)(a) of this section.***

➔SECTION 9. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

***(1) (a) The secretary shall enforce the mandatory reporting requirements in Section 8 of this Act.***

***(b) In carrying out the duties under paragraph (a) of this subsection, the secretary:***

***1. Has the authority to receive complaints and conduct investigations, which includes:***

***a. Receiving sworn statements; and***

***b. Issuing subpoenas to compel the:***

***i. Attendance and testimony of witnesses; and***

***ii. Production of records and other documents;***

***2. May enter an order assessing a civil penalty in accordance with this section;***

***3. Has the power to invoke the aid of the courts through injunction or other proper process to:***

***a. Enjoin any existing or threatened violation of Section 8 of this Act; or***

***b. Enforce any proper order entered under this section; and***

***4. Shall provide a right to an administrative hearing in accordance with KRS Chapter 13B prior to the entry of a final order assessing a civil penalty under this section, except that if a person fails to request an administrative hearing within twenty (20) days of the date of service of any notice of intent to assess a civil penalty under this section, the secretary may enter a final order assessing the civil penalty without conducting a hearing.***

***(2) (a) Subject to paragraphs (b), (c), (d), and (e) of this subsection, the executive director shall promulgate an administrative regulation designating a schedule of penalties, not to exceed one thousand dollars ($1,000) per day, for any participant that fails to comply with a mandatory reporting requirement for that person under Section 8 of this Act.***

***(b) Local government, state, and federal agencies or entities shall not be subject to or assessed a civil penalty under this section.***

***(c) The executive director may, by administrative regulation, adjust the maximum penalty established under paragraph (a) of this subsection every two (2) years based on the percent change in the nonseasonally adjusted annual average Consumer Price Index for All Urban Consumers (CPI-U), U.S. City Average, Medical Care, between the two (2) most recent calendar years available, as published by the United States Bureau of Labor Statistics.***

***(d) The secretary shall promulgate an administrative regulation designating the process for notice, hearing, and collection of any penalty assessed under section.***

***(e) The secretary may, upon terms and conditions that are determined by the secretary to be in the public interest, remit or mitigate any penalty assessed under section.***

***(3) Any penalties collected by the secretary under this section shall be deposited into the Kentucky statewide health data utility fund established in Section 3 of this Act.***

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

***(1) No later than June 1 of each year, the consortium shall submit a written report to the executive director, and the Legislative Research Commission for referral to the appropriate interim joint committees or other appropriate committees, that sets forth the following relating to the statewide health data utility:***

***(a) The status of any development and implementation efforts;***

***(b) A detailed summary of the utility's operations for the previous year;***

***(c) The financial stability of the utility;***

***(d) An assessment of:***

***1. The cost, performance, and effectiveness of the utility;***

***2. The performance of any vendors or contractors that the consortium has retained; and***

***3. Whether the utility has advanced the purposes set forth in Sections 1 to 10 of this Act; and***

***(e) Any recommendations for changes or improvements to the utility.***

***(2) No later than September 1 of each year, the executive director shall submit a written report to the Legislative Research Commission for referral to the appropriate interim joint committees or other appropriate committees that sets forth the following relating to the statewide health data utility:***

***(a) A summary of the executive director's oversight and enforcement activities;***

***(b) Whether the consortium is in compliance with the contract to operate and govern the utility;***

***(c) If the consortium is not in compliance with the contract to operate and govern the utility, a detailed listing and summary of the compliance issues;***

***(d) An assessment of:***

***1. The financial stability of the utility;***

***2. The cost, performance, and effectiveness of the utility;***

***3. The performance of any vendors or contractors that the consortium of public health colleges or executive director has retained; and***

***4. Whether the utility has advanced the purposes set forth in Sections 1 to 10 of this Act; and***

***(e) Any recommendations for changes or improvements to the utility.***

➔Section 11. KRS 194A.030 is amended to read as follows:

The cabinet consists of the following major organizational units, which are hereby created:

(1) Office of the Secretary. Within the Office of the Secretary, there shall be an Office of Legal Services, an Office of Inspector General, an Office of Public Affairs, an Office of Human Resource Management, an Office of Finance and Budget, an Office of Legislative and Regulatory Affairs, an Office of Administrative Services, an Office of Application Technology Services, an Office of Data Analytics, and an Office of Medical Cannabis as follows:

(a) The Office of Legal Services shall provide legal advice and assistance to all units of the cabinet in any legal action in which it may be involved. The Office of Legal Services shall employ all attorneys of the cabinet who serve the cabinet in the capacity of attorney, giving legal advice and opinions concerning the operation of all programs in the cabinet. The Office of Legal Services shall be headed by a general counsel who shall be appointed by the

secretary with the approval of the Governor under KRS 12.050 and 12.210. The general counsel shall be the chief legal advisor to the secretary and shall be directly responsible to the secretary. The Attorney General, on the request of the secretary, may designate the general counsel as an assistant attorney general under the provisions of KRS 15.105;

(b) The Office of Inspector General shall be headed by an inspector general who shall be appointed by the secretary with the approval of the Governor. The inspector general shall be directly responsible to the secretary. The Office of Inspector General shall be responsible for:

1. The conduct of audits and investigations for detecting the perpetration of fraud or abuse of any program by any client, or by any vendor of services with whom the cabinet has contracted; and the conduct of special investigations requested by the secretary, commissioners, or office heads of the cabinet into matters related to the cabinet or its programs;
2. Licensing and regulatory functions as the secretary may delegate;
3. Review of health facilities participating in transplant programs, as determined by the secretary, for the purpose of determining any violations of KRS 311.1911 to 311.1959, 311.1961, and 311.1963;
4. The duties, responsibilities, and authority pertaining to the certificate of need functions and the licensure appeals functions, pursuant to KRS Chapter 216B;
5. The notification and forwarding of any information relevant to possible criminal violations to the appropriate prosecuting authority;
6. The oversight of the operations of the Kentucky Health Information Exchange ***in accordance with Section 13 of this Act***; and
7. The support and guidance to health care providers related to telehealth

services, including the development of policy, standards, resources, and education to expand telehealth services across the Commonwealth;

(c) The Office of Public Affairs shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050. The office shall provide information to the public and news media about the programs, services, and initiatives of the cabinet;

(d) The Office of Human Resource Management shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050. The office shall coordinate, oversee, and execute all personnel, training, and management functions of the cabinet. The office shall focus on the oversight, development, and implementation of quality improvement services; curriculum development and delivery of instruction to staff; the administration, management, and oversight of training operations; health, safety, and compliance training; and equal employment opportunity compliance functions;

(e) The Office of Finance and Budget shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050. The office shall provide central review and oversight of budget, contract, and cabinet finances. The office shall provide coordination, assistance, and support to program departments and independent review and analysis on behalf of the secretary;

(f) The Office of Legislative and Regulatory Affairs shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050. The office shall provide central review and oversight of legislation, policy, and administrative regulations. The office shall provide coordination, assistance, and support to program departments and independent review and analysis on behalf of the secretary;

(g) The Office of Administrative Services shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050. The office shall provide central review and oversight of procurement, general accounting including grant monitoring, and facility management. The office shall provide coordination, assistance, and support to program departments and independent review and analysis on behalf of the secretary;

(h) The Office of Application Technology Services shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050. The office shall provide application technology services including central review and oversight. The office shall provide coordination, assistance, and support to program departments and independent review and analysis on behalf of the secretary;

(i) The Office of Data Analytics shall be headed by an executive director who shall be appointed by the secretary with the approval of the Governor under KRS 12.050**,** and shall**:**

***1.*** Identify and innovate strategic initiatives to inform public policy initiatives and provide opportunities for improved health outcomes for all Kentuckians though data analytics**;**~~[. The office shall ]~~

***2.*** Provide leadership in the redesign of the health care delivery system using electronic information technology to improve patient care and reduce medical errors and duplicative services; and

***3. Comply with Sections 1 to 10 of this Act;***

(j) The Office of Medical Cannabis shall be headed by an executive director appointed by the Governor in accordance with KRS 12.040 and shall implement, operate, oversee, and regulate the medicinal cannabis program. The office shall be composed of the Division of Enforcement and Compliance

and the Division of Licensure and Access. Each division in the office shall be headed by a director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050.

(2) Department for Medicaid Services. The Department for Medicaid Services shall serve as the single state agency in the Commonwealth to administer Title XIX of the Federal Social Security Act. The Department for Medicaid Services shall be headed by a commissioner for Medicaid services, who shall be appointed by the secretary with the approval of the Governor under KRS 12.050. The commissioner for Medicaid services shall be a person who by experience and training in administration and management is qualified to perform the duties of this office. The commissioner for Medicaid services shall exercise authority over the Department for Medicaid Services under the direction of the secretary and shall only fulfill those responsibilities as delegated by the secretary;

(3) Department for Public Health. The Department for Public Health shall develop and operate all programs of the cabinet that provide health services and all programs for assessing the health status of the population for the promotion of health and the prevention of disease, injury, disability, and premature death. This shall include but not be limited to oversight of the Division of Women's Health and the Office for Children with Special Health Care Needs. The duties, responsibilities, and authority set out in KRS 200.460 to 200.490 shall be performed by the Department for Public Health. The Department for Public Health shall advocate for the rights of children with disabilities and, to the extent that funds are available, shall ensure the administration of services for children with disabilities as are deemed appropriate by this office pursuant to Title V of the Social Security Act. The Department for Public Health may promulgate administrative regulations under KRS Chapter 13A as may be necessary to implement and administer its responsibilities. The Office for Children with Special Health Care Needs may be headed by an executive director

appointed by the secretary with the approval of the Governor in accordance with KRS 12.050. The Department for Public Health shall be headed by a commissioner for public health who shall be appointed by the secretary with the approval of the Governor under KRS 12.050. The commissioner for public health shall be a duly licensed physician who by experience and training in administration and management is qualified to perform the duties of this office. The commissioner shall advise the head of each major organizational unit enumerated in this section on policies, plans, and programs relating to all matters of public health, including any actions necessary to safeguard the health of the citizens of the Commonwealth. The commissioner shall serve as chief medical officer of the Commonwealth. The commissioner for public health shall exercise authority over the Department for Public Health under the direction of the secretary and shall only fulfill those responsibilities as delegated by the secretary;

(4) Department for Behavioral Health, Developmental and Intellectual Disabilities. The Department for Behavioral Health, Developmental and Intellectual Disabilities shall develop and administer programs for the prevention of mental illness, intellectual disabilities, brain injury, developmental disabilities, and substance use disorders and shall develop and administer an array of services and support for the treatment, habilitation, and rehabilitation of persons who have a mental illness or emotional disability, or who have an intellectual disability, brain injury, developmental disability, or a substance use disorder. The Department for Behavioral Health, Developmental and Intellectual Disabilities shall be headed by a commissioner for behavioral health, developmental and intellectual disabilities who shall be appointed by the secretary with the approval of the Governor under KRS 12.050. The commissioner for behavioral health, developmental and intellectual disabilities shall be by training and experience in administration and management qualified to perform the duties of the office. The commissioner for behavioral health,

developmental and intellectual disabilities shall exercise authority over the department under the direction of the secretary, and shall only fulfill those responsibilities as delegated by the secretary;

(5) Department for Family Resource Centers and Volunteer Services. The Department for Family Resource Centers and Volunteer Services shall streamline the various responsibilities associated with the human services programs for which the cabinet is responsible. This shall include, but not be limited to, oversight of the Division of Family Resource and Youth Services Centers and Serve Kentucky. The Department for Family Resource Centers and Volunteer Services shall be headed by a commissioner who shall be appointed by the secretary with the approval of the Governor under KRS 12.050. The commissioner for family resource centers and volunteer services shall be by training and experience in administration and management qualified to perform the duties of the office, shall exercise authority over the department under the direction of the secretary, and shall only fulfill those responsibilities as delegated by the secretary;

(6) Department for Community Based Services. The Department for Community Based Services shall administer and be responsible for child and adult protection, guardianship services, violence prevention resources, foster care and adoption, permanency, and services to enhance family self-sufficiency, including child care, social services, public assistance, and family support. The department shall be headed by a commissioner appointed by the secretary with the approval of the Governor in accordance with KRS 12.050; and

(7) Department for Aging and Independent Living. The Department for Aging and Independent Living shall serve as the state unit as designated by the Administration on Aging Services under the Older Americans Act and shall have responsibility for administration of the federal community support services, in-home services, meals, family and caregiver support services, elder rights and legal assistance, senior

community services employment program, the state health insurance assistance program, state home and community based services including home care, Alzheimer's respite services and the personal care attendant program, certifications of assisted living facilities, and the state Council on Alzheimer's Disease and other related disorders. The department shall also administer the Long-Term Care Ombudsman Program and the Medicaid Home and Community Based Waivers Participant Directed Services Option (PDS) Program. The department shall serve as the information and assistance center for aging and disability services and administer multiple federal grants and other state initiatives. The department shall be headed by a commissioner appointed by the secretary with the approval of the Governor in accordance with KRS 12.050.

➔Section 12. KRS 194A.101 is amended to read as follows:

(1) The Office of Data Analytics is hereby created in the Office of the Secretary. The office shall***:***

***(a)*** Provide oversight and strategic direction ***for,*** and be responsible for ***the*** coordinating ***of,*** the data analysis initiatives ***of***~~[for]~~ the various departments that regulate health care and social services to ensure that policy is consistent with the long-term goals across the Commonwealth***; and***

***(b) Comply with Sections 1 to 10 of this Act***.

(2) The office shall have the authority to review all data requests received by the cabinet from the public, review the requests for content to determine the cabinet's response, and approve the release of the requested information. The office shall review data analyses conducted by the departments within the cabinet to ensure the consistency, quality, and validity of the analysis prior to its use in operational and policy decisions. The office shall facilitate the process of data integration by initiating and maintaining data-sharing agreements in order to improve inter-agency and cross-cabinet collaboration.

(3) The Office of Data Analytics shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section.

➔Section 13. KRS 194A.103 is amended to read as follows:

(1) ***(a)*** The Division of Kentucky Health Information Exchange is hereby created in the Office of Inspector General.

***(b)*** The division shall***:***

***1. Continue to operate and support the Kentucky Health Information Exchange until the Kentucky statewide health data utility established in Sections 1 to 10 of this Act becomes operational; and***

***2. Cooperate with, support, and provide assistance to the executive director of the Office of Data Analytics and the consortium of public health colleges created in Section 6 of this Act in the implementation of the health care information exchange and the prescription information exchange within the Kentucky statewide health data utility established in Sections 1 to 10 of this Act***~~[provide leadership in the redesign of the health care delivery system using electronic information technology as a means to improve patient care and reduce medical errors and duplicative services]~~.

(2) The Office of Inspector General shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement the provisions of this section.

➔Section 14. KRS 194A.095 is amended to read as follows:

(1) There is created in the Cabinet for Health and Family Services a Division of Women's Health for the purpose of:

(a) Serving as a repository for data and information affecting women's physical and mental health issues;

(b) Analyzing and communicating trends in women's health issues and mental health;

(c) Recommending to the cabinet~~[ for Health and Family Services]~~ data elements affecting women's physical and mental health. The division shall advise and direct which data elements should be collected, analyzed, and reported in a timely manner under ***the Kentucky statewide health data utility established in Sections 1 to 10 of this Act or, to the extent the statewide health data utility is not operational, under any other operational health data reporting law of this state***~~[KRS 216.2920 to 216.2929]~~;

(d) Cooperating and collaborating with the cabinet~~[ for Health and Family Services]~~ in receiving and disseminating through all forms of media**,** including the internet**,** relevant aggregate data findings ***that affect women and are collected from the Kentucky statewide health data utility established in Sections 1 to 10 of this Act or, to the extent the statewide health data utility is not operational, under any other operational health data reporting law of this state***~~[under KRS 216.2920 to 216.2929 which affect women]~~; and

(e) Planning, developing, and administering a Women's Health Resource Center within the cabinet~~[ for Health and Family Services]~~ to focus on targeted preventive care and comprehensive health education.

(2) The division may accept gifts, grants, and bequests in support of its mission and duties specified in~~[ subsection (1) of]~~ this section. All money received shall be administered by the cabinet, which shall administer these funds through appropriate trust and agency accounts.

➔Section 15. KRS 205.640 is amended to read as follows:

(1) The commissioner of Medicaid services shall adopt a disproportionate share program consistent with the requirements of Title XIX of the Social Security Act which shall include to the extent possible, but not limited to, the provisions of this section.

(2) The Medical Assistance Revolving Trust Fund (MART) shall be established in the

State Treasury and all provider tax revenues collected pursuant to KRS 142.301 to 142.363 shall be deposited in the State Treasury and transferred on a quarterly basis to the Department for Medicaid Services for use as specified in this section. All investment earnings of the fund shall be credited to the fund. Provider tax revenues collected in accordance with KRS 142.301 to 142.363 may be used to fund the provisions of ***Sections 1 to 10 of this Act***~~[KRS 216.2920 to 216.2929]~~ and to supplement the medical assistance-related general fund appropriations for fiscal year 1994 and subsequent fiscal years. Notwithstanding the provisions of KRS 48.500 and 48.600, the MART fund shall be exempt from any state budget reduction acts.

(3) (a) Beginning in state fiscal year 2000-2001 and continuing annually thereafter, provider tax revenues and state and federal matching funds shall be used to fund the disproportionate share program established by administrative regulations promulgated by the Cabinet for Health and Family Services. Disproportionate share funds shall be divided into three (3) pools for distribution as follows:

1. An acute care pool, composed of critical access hospitals, comprehensive physical rehabilitation hospitals, long-term acute hospitals, and acute care hospitals that do not qualify as a university hospital, shall receive an initial and a final allocation determined by subtracting from the state's total DSH allotment:
   a. The allocation required in subparagraph 2. of this paragraph for the psychiatric pool; and
   b. The initial or final, as applicable, DSH payments to be made to hospitals in the university pool in subparagraph 3. of this paragraph;
2. A psychiatric pool, composed of private psychiatric hospitals and state

mental hospitals, shall receive the percentage allowable by federal law pursuant to 42 U.S.C. sec. 1396r-4(h), up to nineteen and eight-hundredths percent (19.08%) of the total disproportionate share funds, with the allocation between each respective group of hospitals established by the biennial budget; except, however, that the allocation to state mental hospitals shall not exceed ninety-two and three-tenths percent (92.3%) of the total allotment to the psychiatric pool. If there are remaining funds within the psychiatric pool after all private psychiatric hospitals reach their hospital-specific DSH limit, state mental hospitals may exceed the ninety-two and three-tenths percent (92.3%) limit but may not exceed their hospital-specific DSH limit;

3. A university hospital pool, composed of university hospitals, shall receive thirty-seven percent (37%) of the state's DSH allotment; except, however, that initial and final DSH payments to university hospitals shall be determined according to paragraph (e) of this subsection and not exceed the pool's overall allotment;

4. If there are any remaining disproportionate share funds from the psychiatric pool, fifty-four percent (54%) of those funds shall be distributed to the acute care pool and forty-six percent (46%) shall be distributed to the university pool. If the university hospitals are unable to absorb additional DSH payment dollars, remaining funds shall be distributed to the acute care pool; and

5. If, in any year, university hospitals fail to provide state matching funds necessary to secure federal financial participation for the funds allocated to university hospitals under this subsection, the portion of the funding allocation that is not matched by university hospitals shall be made available to the acute care pool.

(b) The MART fund shall be used to compensate acute care hospitals, private psychiatric hospitals, state mental hospitals, critical access hospitals, comprehensive physical rehabilitation hospitals, long-term acute care hospitals, and university hospitals participating in the disproportionate share program for uncompensated care costs.

(c) An individual hospital shall receive distributions if the hospital meets the requirements of the disproportionate share program pursuant to 42 U.S.C. sec. 1396r-4.

(d) 1. An individual hospital shall not receive an initial DSH payment unless the hospital submits a Medicaid DSH survey by the deadline established by subsection (8)(a) of this section, unless the deadline has been extended by the commissioner of the department. Extension requests shall be received at least ten (10) days prior to the deadline. Extensions shall be limited to rare circumstances which prevent the hospital from meeting the deadline despite due diligence. Extensions shall be granted for no more than thirty (30) calendar days from the original due date for the Medicaid DSH survey. Failure to submit a DSH survey in a timely manner or other required information for receipt of an initial DSH payment shall result in an individual hospital's final DSH payment being reduced by twenty percent (20%).

2. A hospital newly enrolled in the Medicaid program, which does not have at least six (6) months of cost report information necessary to calculate an initial DSH payment, may submit a limited DSH survey for the purpose of determining if the hospital is eligible to receive an initial DSH payment.

(e) Distributions shall be made as follows:

1. For state fiscal year 2018-2019, the department shall use the examined

state fiscal year 2014-2015 DSH survey to calculate an initial DSH payment. Providers who did not receive a DSH payment for state fiscal year 2014-2015 shall be eligible to submit data for the purpose of the 2019 payment, subject to limited review. For state fiscal year 2019-2020, and each year thereafter, the department shall use the Medicaid DSH survey covering the hospital's fiscal year ending in the calendar year preceding July 1 of the applicable state fiscal year to calculate an initial DSH payment. Using the surveys submitted in accordance with this subsection, payments shall be made as follows:

a. Each university hospital in the university pool shall receive an initial DSH payment equal to one hundred percent (100%) of the hospital's total uncompensated care costs if the total initial DSH payments to all hospitals in the university pool do not exceed the maximum allotment to the university pool as set forth in subsection (3)(a) of this section. If the total uncompensated care costs for the pool exceed the pool's maximum allotment, the initial uncompensated care factor for university hospitals shall be determined by calculating the percentage of each hospital's total uncompensated care costs toward the sum of the total uncompensated care costs of all hospitals in the university pool, and each hospital's initial DSH payment shall be calculated by multiplying the hospital's initial uncompensated care factor by the total funds allocated to the university hospital pool;

b. For each private psychiatric and state mental hospital in the psychiatric pool, the department shall calculate an initial uncompensated care factor. The initial uncompensated care factor for a private psychiatric or state mental hospital shall be

determined by calculating the percentage of each hospital's total uncompensated care costs toward the sum of the total uncompensated care costs for all private psychiatric or state mental hospitals in the psychiatric pool, as appropriate. Each hospital's initial DSH payment shall be calculated by multiplying the hospital's initial uncompensated care factor by the total funds allocated to private psychiatric or state mental hospitals in the psychiatric pool, as appropriate. No individual hospital's initial DSH payment shall exceed the hospital's hospital-specific DSH limit;

c. For each hospital in the acute care pool, the department shall make an initial determination of whether the acute care hospital qualifies as an essential hospital and calculate an initial uncompensated care factor for each hospital. The initial uncompensated care factor for each hospital in the acute care pool shall be determined by calculating the percentage of each hospital's total uncompensated care costs toward the sum of the total uncompensated care costs for all hospitals in the acute care pool except that the initial uncompensated care factor for an essential hospital shall be calculated using two hundred percent (200%) of the hospital's total uncompensated care costs. Each hospital's initial DSH payment shall be calculated by multiplying the hospital's initial uncompensated care factor by the total funds allocated to the acute care pool. No individual hospital's initial DSH payment shall exceed the hospital's hospital-specific DSH limit;

d. For any hospital that is newly enrolled in the Medicaid program and lacks at least six (6) months of cost report information, the

department shall calculate a proxy amount for the hospital's uncompensated care costs. A newly enrolled hospital's uncompensated care costs proxy amount shall be determined by first dividing the total uncompensated care costs for all non-newly enrolled hospitals in the appropriate pool by the total number of hospital beds, excluding swing beds, reported on the Medicaid cost reports by those hospitals and then multiplying the resulting uncompensated care cost per bed by the new hospital's total number of hospital beds, excluding swing beds. Any uncompensated care costs proxy amounts calculated for newly enrolled hospitals shall be used in the determination of initial uncompensated care factors for all other hospitals in the appropriate pool;

e. The department may make adjustments to a Medicaid DSH survey filed by a hospital to correct information that is incomplete or inaccurate as determined by limited review. If the department makes adjustments to a hospital's Medicaid DSH survey, the department shall provide written notice to the hospital;

f. If a hospital has a negative uncompensated care cost, its uncompensated care costs shall be excluded from the calculation of any uncompensated care costs proxy amount for newly enrolled hospitals and uncompensated care factors for the appropriate pool;

g. By September 30 of each year, the department shall calculate an initial DSH payment pursuant to subparagraph 1. of this paragraph and shall notify each hospital of their calculation. The notice shall, at minimum, contain the following for each hospital:

i. Uninsured uncompensated care costs;

ii. Total uncompensated care costs;

iii. The status of the MIUR and LIUR calculations;

iv. The uncompensated care factor; and

v. The estimated initial annual payment amount;

h. Hospitals shall notify the department by October 31 of any adjustments in the department's initial calculations;

i. The department shall make any necessary adjustments and shall issue an initial DSH payment to each hospital in one (1) lump-sum payment on or before November 30, for the disproportionate share funds available during the corresponding federal fiscal year. If the federal disproportionate share allotment for the Commonwealth has not been published through the Federal Register by November 15, the department may pay a portion but no less than ninety percent (90%) of the expected annual payment prior to the publication of the annual federal allotment. If a partial initial payment is made, the remaining amount shall be paid within sixty (60) days after the date upon which notice of the Commonwealth's federal allotment is published through the Federal Register; and

j. An initial DSH payment shall not be subject to appeal;

2. a. Each hospital's total initial DSH payment shall be reconciled to a final DSH payment using the examined Medicaid DSH surveys and shall correspond to the applicable state fiscal year DSH payment year.

b. Using the surveys submitted in accordance with subsection (8)(a) of this section, the department shall make a final determination of whether an acute care hospital qualifies as a MIUR or as a LIUR hospital. Any qualifying hospital will be deemed an essential

hospital. Critical access hospital status will also be confirmed to make a final determination of essential hospital status.

c. The department shall calculate a final DSH payment as follows:

i. Each university hospital shall receive a final DSH payment equal to one hundred percent (100%) of the hospital's total uncompensated costs so long as the total final DSH payments to all university hospitals do not exceed the maximum allotment to the university pool as set forth in subsection (3)(a) of this section. If total uncompensated care cost for the pool exceeds the pool's maximum allotment, the final uncompensated care factor for university hospitals shall be determined by calculating the percentage of each hospital's total uncompensated care costs toward the sum of the total uncompensated care costs for all hospitals within the university pool. In this event, each hospital's final DSH payment shall be calculated by multiplying the hospital's uncompensated care factor by the total fund allocated to the hospitals within the respective pool under subsection (3)(a) of this section;

ii. For hospitals in the acute care pool and the psychiatric pool, the department shall recalculate each hospital's uncompensated care factor using examined data. The final uncompensated care factor for each hospital that qualifies as an essential hospital shall be computed using two hundred percent (200%) of the hospital's total uncompensated care costs using examined data;

iii. If a hospital has a negative uncompensated care cost, their

uncompensated care cost will be excluded in the calculation of uncompensated care factors; and

iv. The department shall compare each hospital's initial DSH payment with the hospital's final DSH payment and with the hospital's hospital-specific DSH limit to determine if any underpayment or an overpayment exists.

d. By September 30 of the fourth year following the year in which an initial DSH payment is made, the department shall provide each hospital with a final DSH reconciliation report which, at a minimum, shall indicate the following:

i. A hospital's final MIUR and LIUR status;

ii. Final uncompensated care factor and underlying data;

iii. Final DSH payment; and

iv. If applicable, the amount of any overpayment to be paid to the department and the due date for repayment.

e. If an overpayment is identified, repayment shall be made by January 31 of the following year, which is five (5) years following the year in which an initial DSH payment is made.

f. Hospitals shall notify the department by October 31 of any corrections to the department's calculations.

g. If a hospital's initial DSH payment was less than the hospital's final DSH payment, the department shall pay the hospital the amount of the difference. Final DSH payments shall be issued by the department within sixty (60) days of the due date for the repayment of funds from hospitals with a DSH overpayment. If all repayments have not yet been received by the due date, the department shall distribute the funds collected as of the due date,

and shall issue additional payments on a timely basis upon collection of all remaining outstanding overpayments.

h. Any funds remaining after the reconciliation process shall be redistributed pursuant to subparagraph 3. of this paragraph; and

3. Disproportionate share payments remaining after reconciling each hospital's initial DSH payment with the hospital's final DSH payment shall be distributed to other hospitals in the acute care pool, university pool, or to private psychiatric hospitals in the psychiatric pool as follows:

a. Funds shall first be distributed to all hospitals in the same pool as the hospitals from which the overpayments were recovered, and the funds shall be distributed in a proportional manner in relation to each hospital's remaining total uncompensated care costs in accordance with the hospital's examined DSH survey for the applicable DSH year;

b. In the proportional distribution, the distribution factor for each hospital that qualifies as an essential hospital shall be computed using two hundred percent (200%) of the hospital's total remaining uncompensated care costs; and

c. If DSH funds remain after making this distribution to other hospitals in the same pool, funds shall be distributed proportionally to hospitals in the acute care pool, university pool, and private psychiatric hospitals in the psychiatric pool in relation to each hospital's remaining total uncompensated care costs in accordance with the hospital's examined Medicaid DSH survey for the applicable DSH year.

(4) Notwithstanding any other provision to the contrary, total annual disproportionate

share payments made to state mental hospitals, university hospitals, acute care hospitals, critical access hospitals, comprehensive physical rehabilitation hospitals, long-term acute care hospitals, and private psychiatric hospitals in each state fiscal year shall be equal to the maximum amount of disproportionate share payments established under the Federal Balanced Budget Act of 1997 and any amendments thereto. Disproportionate share payments made to a hospital shall not exceed the hospital's total uncompensated costs or the hospital's hospital-specific DSH limit.

(5) The secretary of the Cabinet for Health and Family Services shall promulgate administrative regulations, pursuant to KRS Chapter 13A, for the administration and implementation of this section.

(6) All hospitals receiving reimbursement under this section shall display prominently a sign which reads as follows: "This hospital will accept patients regardless of race, creed, ethnic background, or ability to pay."

(7) The hospital shall, upon request by the Cabinet for Health and Family Services, submit any supporting documentation to substantiate compliance with the audit requirements established by 42 C.F.R. sec. 455.

(8) (a) An in-state hospital participating in the Medicaid Program shall submit a Medicaid DSH survey corresponding to the hospital's cost reporting period to the department no later than sixty (60) days following the hospital's submission of their annual cost report, unless an extension has been granted by the commissioner. Extension requests shall be received ten (10) days prior to the deadline. Extensions shall be limited to rare circumstances which prevent the hospital from meeting the deadline despite its due diligence. Extensions shall be granted for no more than thirty (30) calendar days from the original due date. A new in-state hospital lacking six (6) months of cost report information necessary to calculate an initial DSH payment shall submit a limited DSH survey to determine eligibility no later than the September 1

immediately prior to the department's initial DSH payment calculation. A hospital may submit corrections to an applicable Medicaid DSH survey prior to the scheduled start date of the department's desk review.

(b) The department shall notify each hospital in advance of the desk review of the opportunity to submit corrections to the Medicaid DSH survey.

(c) The department and each Medicaid managed care organization shall supply a paid claims listing (PCL) to each hospital within ninety (90) days of the last day of the hospital's fiscal year end date and a second set of data twelve (12) months after the hospital's fiscal year end date. The PCL shall include all claims with discharge dates or service dates, as applicable, within the hospital's fiscal year that are paid from the first day of the hospital's fiscal year to ninety (90) days or twelve (12) months, respectively, after the end of the hospital's fiscal year. For all hospitals, the department and each Medicaid managed care organization shall provide separate reports for adjudicated claims associated with both inpatient services and outpatient services provided to eligible members. If the PCL data is inaccurate or unavailable, providers shall complete the DSH survey using internal data.

(d) The department shall specify a timetable for hospitals to update DSH audit survey data.

➔Section 16. KRS 205.6489 is amended to read as follows:

(1) The Kentucky Children's Health Insurance Program shall be administered by the Cabinet for Health and Family Services in terms of conducting eligibility determination and providing oversight over enrollment and claims payment.

(2) The program shall include a system of outreach and referral for children who may be eligible for the Kentucky Children's Health Insurance Program. The program shall work with the Department for Medicaid Services, the Department for Community Based Services, schools, pediatricians, public health departments, and

other entities interested in the health of children in developing the system of outreach and referral.

(3) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A to establish a structure for quality assurance and utilization review under KRS 205.6481 to 205.6495 and KRS 304.17A-340.

(4) The Kentucky Children's Health Insurance Program shall collect, analyze, and publicly disseminate comprehensive data on the number of children enrolled in the program, services received through the program, and the effect on health outcomes of children served by the program including the special health needs of minority children. The information collected by the program shall be subject to ***the Kentucky statewide health data utility established in Sections 1 to 10 of this Act or, to the extent the statewide health data utility is not operational, to any other operational health data reporting law of this state***~~[KRS 216.2927(1)]~~. The program shall~~[ have access to all data collected by the cabinet under KRS 216.2920 to 216.2929 and shall]~~ coordinate program data collection efforts with the data collection efforts of ***the Kentucky statewide health data utility***~~[the cabinet under KRS 216.2920 to 216.2929]~~.

➔Section 17. KRS 211.474 is amended to read as follows:

The board shall:

(1) Promulgate administrative regulations ***in accordance with KRS Chapter 13A as*** necessary to carry out the provisions of KRS 211.470 to 211.478;

(2) Formulate policies and procedures for determining individual eligibility for assistance from the trust fund in accordance with the following guidelines:

(a) The trust fund shall serve as a funding source of last resort for residents of the Commonwealth of Kentucky. To be eligible for assistance from the trust fund, an individual must have exhausted all other funding sources that cover the type of services sought through the trust fund. Individuals who have

continuing health insurance benefits, including Medicaid, may access the trust fund for services that are needed but not covered by insurance or any other funding source. Individuals who qualify for institutional care through Medicaid shall not qualify for services through the trust fund;

(b) All individuals receiving assistance from the fund shall receive case management services;

(c) Expenditures on behalf of any one (1) brain-injured individual may not exceed fifteen thousand dollars ($15,000) for any twelve (12) month period, and may not exceed a lifetime maximum of sixty thousand dollars ($60,000). At its discretion and subject to fund availability, the board may waive the expenditure or time limitations or both in special circumstances;

(d) Services covered by the trust fund shall include:

1. Case management;
2. Community residential services;
3. Structured day program services;
4. Psychological and mental health services;
5. Prevocational services;
6. Supported employment;
7. Companion services;
8. Respite care;
9. Occupational therapy; and
10. Speech and language therapy;

(e) Covered services shall not include institutionalization, hospitalization, or medications;

(3) Establish a confidential medical registry for traumatic brain and spinal cord injuries occurring in the Commonwealth of Kentucky, or to residents of the Commonwealth of Kentucky.

(a) ***1.*** The board may promulgate administrative regulations requiring licensed or certified professionals or health services providers to report the occurrence of brain and spinal cord injuries, relevant medical and epidemiological information about the injuries, and other information describing the circumstances of the injury to the board or its designated agent.

***2.*** The reporting of data by licensed hospitals under this section shall be limited to that which is***:***

***a. Accessible from the Kentucky statewide health data utility established in Sections 1 to 10 of this Act; or***

***b. To the extent the statewide health data utility is not operational,*** reported to the cabinet pursuant to ***any other operational health data reporting law of this state;***~~[KRS 216.2920 to 216.2929]~~ and the board shall obtain this data from the cabinet.

***3.*** Each licensed hospital shall grant the board, upon presentation of proper identification, access to the medical records of patients with reportable brain and spinal cord injuries for the sole purpose of collecting additional information that is not available in the data obtained from the cabinet. All costs associated with copying medical records shall be borne by the board. No liability of any kind shall arise or be enforced against any licensed hospital or hospital employee for providing the board access to a patient's medical record.

(b) The board and its designated agent, if one is appointed, shall observe the same confidentiality requirements established for the Kentucky birth surveillance registry in KRS 211.670;

(4) Investigate the needs of brain-injured individuals and identify gaps in current services;

(5) Assist the cabinet in developing programs for brain-injured individuals;

(6) Monitor and evaluate services provided by the trust fund; and

(7) Provide the Governor~~[, the General Assembly,]~~ and the Legislative Research Commission an annual report by January 1 of each year summarizing the activities of the board and the trust fund.

➔Section 18. KRS 214.375 is amended to read as follows:

(1) As used in this section:

(a) "Advisory committee" means the Kentucky Parkinson's Disease Research Registry Advisory Committee established under subsection (3) of this section;

(b) "Cabinet" means the Cabinet for Health and Family Services;

(c) "Movement disorder center" means a health facility licensed under KRS Chapter 216B that operates outpatient clinics or ambulatory care facilities that employ movement disorder health care providers;

(d) "Movement disorder health care provider" means a licensed physician or osteopath licensed under KRS Chapter 311 that is fellowship trained in movement disorders as specified by either the American Academy of Neurology's Movement Disorders Section or the Movement Disorder Society's Pan American Section;

(e) "Parkinson's disease" means a chronic and progressive neurologic disorder resulting from a deficiency of the neurotransmitter dopamine as a consequence of specific degenerative changes in the area of the brain called the basal ganglia characterized by tremor at rest, slow movements, muscle rigidity, stooped posture, and unsteady or shuffling gait;

(f) "Parkinsonisms":

1. Means Parkinson's disease-related conditions that cause a combination of movement abnormalities such as tremor at rest, slow movement, muscle rigidity, impaired speech, and muscle stiffness, which often

overlap with and can evolve from what appears to be Parkinson's disease; and

2. Includes multiple system atrophy, dementia with Lewy bodies, corticobasal degeneration, and progressive supranuclear palsy;

(g) "Registry" means the Kentucky Parkinson's Disease Research Registry established in subsection (2) of this section; and

(h) "Secretary" means the secretary of the cabinet.

(2) The Kentucky Parkinson's Disease Research Registry is hereby established within the cabinet under the direction of the secretary, who may enter into contracts, grants, or other agreements as necessary to administer the registry in accordance with this section.

(3) (a) The secretary shall establish the Kentucky Parkinson's Disease Research Registry Advisory Committee to assist in the development and implementation of the registry, determine what data will be collected, and advise the cabinet.

(b) The advisory committee shall be appointed by the secretary and include at least one (1):

1. Neurologist;
2. Movement disorder specialist;
3. Primary care provider;
4. Physician informaticist;
5. Patient living with Parkinson's disease;
6. Public health professional;
7. Population health researcher familiar with health data registries;
8. Parkinson's disease researcher;
9. Representative from the University of Kentucky College of Medicine with specific expertise in Parkinson's disease; and

10. Representative from the University of Louisville School of Medicine with specific expertise in Parkinson's disease.

The secretary may appoint additional members to the advisory committee as he or she deems necessary.

(4) The cabinet shall:

(a) Promulgate administrative regulations in consultation with the advisory committee and in accordance with KRS Chapter 13A to:

1. Designate Parkinson's disease and identified Parkinsonisms as diseases that are required to be reported to the cabinet;

2. Establish a system of collection and dissemination of information on the incidence and prevalence of Parkinson's disease and Parkinsonisms in Kentucky and related epidemiological data;

3. Identify specific data points to be collected based on the following four (4) core categories of data:

a. Patient demographics;

b. Geography;

c. Diagnosis; and

d. Sufficient information to allow for deduplication of patient records in the registry;

4. Periodically review and revise data points to be collected to ensure data and data collection procedures adapt to new knowledge and technology;

5. Establish a coding system that removes a patient's name, address, Social Security number, fingerprints, photograph, and any other information by which the identity of a patient can be determined with reasonable accuracy; and

6. Develop guidelines and procedures for reviewing and approving requests to use registry data for valid scientific research;

(b) Receive and collect data for the registry on the incidence and prevalence of Parkinson's disease and Parkinsonisms in Kentucky and related epidemiological data, and may enter into data-sharing contracts with data-reporting entities and their associated medical record system vendors to securely and confidentially receive information related to Parkinson's disease testing, diagnosis, and treatment; and

(c) Be responsible for any costs incurred in administering the registry and implementing this section.

(5) (a) Beginning January 1, 2026, each movement disorder center that treats a patient with Parkinson's disease and each movement disorder health care provider who treats or diagnoses Parkinson's disease or Parkinsonisms for a patient not otherwise reported shall submit a Parkinson's disease report to the cabinet in a format required or approved by the cabinet.

(b) 1. Movement disorder centers and movement disorder health care providers shall provide each patient diagnosed with Parkinson's disease or Parkinsonisms with a notice regarding the reporting and collection of information and patient data on Parkinson's disease.

2. A patient who does not wish to participate in the collection of data for the purposes of research in the registry may affirmatively opt out in writing after an opportunity to review the documents and ask questions.

3. If a patient has chosen not to participate and has opted out under subparagraph 2. of this paragraph, the movement disorder center and the movement disorder health care provider shall only report that a Parkinson's disease case exists and no further data shall be reported to the cabinet for the purposes of the registry.

4. If a patient has been diagnosed with Parkinson's disease or Parkinsonsisms in error, the movement disorder center and the

movement disorder health care provider shall notify the cabinet and the cabinet shall remove the patient from the registry.

(c) To ensure compliance with the reporting and notification requirements of this subsection, the secretary or his or her agent may, upon reasonable notice, inspect a representative sample of the medical records of patients admitted, diagnosed, or treated for Parkinson's disease or Parkinsonisms at a movement disorder center.

(d) A movement disorder center or movement disorder health care provider who in good faith submits a report in accordance with paragraph (a) of this subsection is not liable in any cause of action arising from the submission of the report.

(e) A movement disorder center or movement disorder health care provider may use automated reporting methods supplied by the cabinet or ***a***~~[the Kentucky]~~ health information exchange ***established under KRS Chapter 194A*** to meet the requirements of this subsection.

(6) The cabinet shall make data from the registry, with or without identifiers, available to researchers that have the approval of an institutional review board in accordance with requirements of the Federal Policy for the Protection of Human Subjects, 45 C.F.R. pt. 46, and, as applicable, 21 C.F.R. pt. 56, 45 C.F.R. pt. 164,~~[ KRS 216.2920 to 216.2929, 900 KAR 7:030 and 7:040,]~~ and any other relevant federal or state requirements.

(7) (a) The cabinet may enter into agreements to furnish data collected in the registry to other states' Parkinson's disease registries, federal Parkinson's disease control agencies, local health officers, or health researchers not described in subsection (6) of this section for the study of Parkinson's disease.

(b) Before confidential information is disclosed pursuant to paragraph (a) of this subsection, the out-of-state registry, agency, officer, or researcher shall agree

in writing to maintain the confidentiality of the information. A researcher shall also:

1. Obtain approval of the researcher's respective committee for the protection of human subjects under 45 C.F.R. pt. 46; and
2. Provide documentation to the cabinet that demonstrates to the cabinet's satisfaction that the researcher has established the procedures and ability to maintain the confidentiality of the information.

(8) (a) Except as specifically provided in this section, all information collected pursuant to this section shall be confidential.

(b) Notwithstanding any other provision of law, a disclosure authorized by this section shall include only the information necessary for the stated purpose of the requested disclosure, used for the approved purpose, and not be further disclosed.

(c) Provided the security of confidentiality has been documented, the furnishing of confidential information to the cabinet or its authorized representative in accordance with this section shall not expose any person, agency, or entity furnishing information to liability, and shall not be considered a waiver of any privilege or a violation of a confidential relationship.

(d) The cabinet shall maintain an accurate record of all persons who are given access to information collected by the cabinet pursuant to this section, which shall include:

1. The name of the person authorizing access;
2. Name, title, address, and organizational affiliation of persons given access;
3. Dates of access; and
4. The specific purpose for which accessed information is to be used.

The record of access shall be open to public inspection during normal

operating hours of the cabinet.

(e) Notwithstanding any other provision of law, information collected by the cabinet pursuant to this section shall not be:

1. Available for subpoena or disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding; or

2. Deemed admissible as evidence in any civil, criminal, administrative, or other proceeding for any reason.

(9) This section does not:

(a) Prohibit the publication by the cabinet of reports and statistical compilations that do not in any way identify individual patients, cases, or sources of information;

(b) Restrict in any way a patient's access to his or her own information; or

(c) Prohibit movement disorder center or movement disorder health care providers from maintaining their own facility-based Parkinson's disease registries.

(10) (a) Nothing in this section shall be deemed to compel any individual to submit to any medical examination or supervision by the cabinet, any of its authorized representatives, or an approved researcher.

(b) A person who seeks information or obtains registry data pursuant to this section shall not contact a patient on the registry or the patient's family unless the cabinet has first obtained permission for the contact from the patient or the patient's family.

(11) The cabinet shall provide notice of the mandatory reporting of Parkinson's disease and Parkinsonisms required under this section on its website and to professional associations representing movement disorder center and movement disorder health care providers.

(12) (a) By October 1, 2027, and October 1 of each year thereafter, the cabinet shall

submit to the Legislative Research Commission for referral to the Interim Joint Committee on Health Services a yearly program summary update that includes:

1. The incidence and prevalence of Parkinson's disease and Parkinsonisms in the state by county;
2. The number of records that have been reported to the cabinet and included in the registry; and
3. Demographic information, including but not limited to patients' age, gender, and race.

(b) In consultation with the advisory committee, the cabinet may include recommendations on necessary changes to the registry in the yearly program summary update.

(c) The cabinet shall publish the yearly program summary update in a downloadable format on the website created under subsection (13) of this section.

(13) By October 1, 2027, the cabinet shall create, and update annually thereafter, the Kentucky Parkinson's Disease Research Registry website where the public can find information related to the Parkinson's disease and the registry, the yearly program summary update, and any other information deemed relevant by the advisory committee.

➔Section 19. KRS 311A.190 is amended to read as follows:

(1) Each licensed ambulance provider, mobile integrated healthcare program, and medical first response provider as defined in this chapter shall collect and provide to the board patient care record data and information required by the board by this chapter and administrative regulation.

(2) The board shall develop a patient care record form for the use of each class of ambulance provider, mobile integrated healthcare program, and medical first

response provider containing the data required in subsection (1) of this section. An ambulance provider, mobile integrated healthcare program, or medical first response provider may utilize any patient care record form it chooses in lieu of or in addition to the board developed patient care record form. However, the data captured on the patient care record form utilized by the ambulance service, mobile integrated healthcare program, or medical first response provider shall include at least the data that is required by the administrative regulations promulgated pursuant to subsection (1) of this section.

(3) An ambulance provider, mobile integrated healthcare program, or medical first response provider shall report the required patient care record data as prescribed through administrative regulations promulgated by the board by transmitting the required data and information to the board in an electronic format. If the board requires the use of a specific electronic format, it shall provide a copy of the file layout requirements, in either written or electronic format, to the licensed ambulance provider or medical first response provider at no charge.

(4) The board shall publish a comprehensive annual report reflecting the data collected, injury and illness data, treatment utilized, and other information deemed important by the board. The annual report shall not include patient identifying information or any other information identifying a natural person. A copy of the comprehensive annual report, if issued, shall be forwarded to the Governor and the General Assembly.

(5) Ambulance provider, mobile integrated healthcare program and medical first response provider patient care records and the information transmitted electronically to the board shall be confidential and in compliance with HIPAA privacy rules referenced in 45 C.F.R. pt. 164. No person shall make an unauthorized release of information on an ambulance provider, mobile integrated healthcare program, or medical first response provider patient care record. Only the patient or

the patient's parent or legal guardian if the patient is a minor, or the patient's legal guardian or person with proper power of attorney if the patient is under legal disability as being incompetent or mentally ill, or a court of competent jurisdiction may authorize the release of information on a patient's care record or the inspection or copying of the patient care record. Any authorization for the release of information or for inspection or copying of a patient care record shall be in writing.

(6) An ambulance provider or medical first response provider that collects patient data through electronic means shall have the means of providing a patient care record or summary report that includes all required data elements to the medical care facility. A copy of the medical first response patient care record or summary report of the patient care record and patient information shall be made available to the ambulance service that transports the patient. A copy of the ambulance transportation and medical report forms shall be made available to any medical care facility to which a patient is transported and shall be included in the patient's medical record by that facility. If a patient is not transported to a medical facility, the copy of the patient care record that is to be given to the transporting ambulance provider or medical care facility shall be given to the patient or to the patient's parent or legal guardian upon request. If the ambulance provider, medical facility, patient, or patient's legal guardian refuses delivery of their patient care record or is unavailable to receive the form, that copy of the patient care record shall be returned to the medical first response provider or ambulance provider and destroyed.

(7) All ambulance services and mobile integrated healthcare programs shall be required to keep adequate reports and records to be maintained at the ambulance base headquarters and to be available for periodic review as deemed necessary by the board. Required records and reports are as follows:

(a) Employee records, including a resume of each employee's training and

experience and evidence of current certification or licensure; and

(b) Health records of all personnel including records of all illnesses or accidents occurring while on duty.

(8) Data and records generated and kept by the board or its contractors regarding the evaluation of emergency medical care, mobile integrated healthcare programs, and trauma care in the Commonwealth, including the identities of patients, emergency medical services personnel, ambulance providers, medical first-response providers, and emergency medical facilities, shall be confidential, shall not be subject to disclosure under KRS 61.805 to 61.850 or KRS 61.870 to 61.884, shall not be admissible in court for any purpose, and shall not be subject to discovery. However, nothing in this section shall limit the discoverability or admissibility of patient medical records regularly and ordinarily kept in the course of a patient's treatment that otherwise would be admissible or discoverable.

(9) The Cabinet for Health and Family Services shall have complete and immediate access to all data and records maintained by the board or its contractors and may use information contained in the data and records to fulfill its responsibilities and requirements for health facilities and services, including but not limited to those duties assigned to the cabinet by KRS 194A.101~~[, 216.2920 to 216.2929,]~~ and 216B.042.

➔Section 20. The following KRS sections are repealed:

216.2920 Definitions for KRS 216.2920 to 216.2929.

216.2921 Duties of cabinet -- Chief administrative officer -- Secretary or employee not subject to personal liability.

216.2923 Health data collection powers and duties -- Analysis of health-care and insurance experience -- Administrative regulations.

216.2925 Administrative regulations -- Reports, lists, forms, and formats required.

216.2927 Types of data not to be published, released, or subject to inspection -- Public-

use data agreements and privacy rules -- Confidentiality of raw data -- Penalty for violation.

216.2929 Data on health-care services charges and quality and outcome measures to be publicly available on cabinet's website -- Reports required.

➔Section 21. Section 20 of this Act takes effect July 1, 2028.

➔Section 22. (1) The secretary of the Cabinet for Health and Family Services shall make all initial appointments under subsection (2)(a) of Section 7 of this Act within 90 days after the effective date of that section.

(2) Notwithstanding subsection (2)(c)2. of Section 7 of this Act, initial appointments under subsection (2)(a) of Section 7 of this Act shall be staggered so that, of the initial 14 appointments:

(a) Five of the appointments expire four years after the initial appointment;

(b) Five of the appointments expire three years after the initial appointment; and

(c) Four of the appointments expire two years after the initial appointment.

➔Section 23. 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 Section 8 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 Section 8 of this Act; and

(2) May only delay implementation of the provisions of Section 8 of this Act for which federal authorization or approval was deemed necessary until the federal authorization or approval is granted.

➔Section 24. Sections 8 and 23 of this Act constitute the specific authorization required under KRS 205.5372(1).