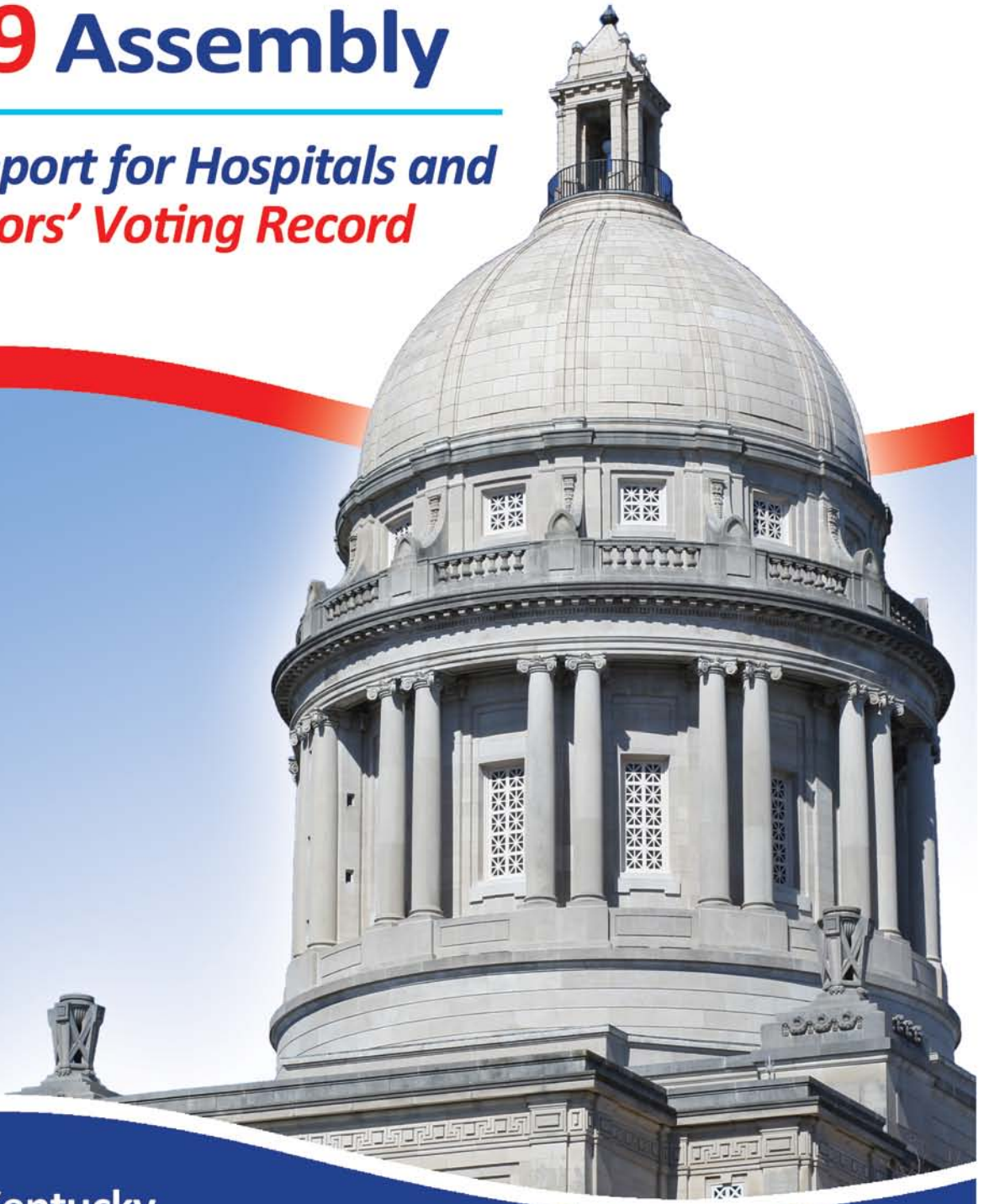




# Kentucky General 2019 Assembly

*Final Report for Hospitals and  
Legislators' Voting Record*

April 2019



Kentucky  
Hospital  
Association

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# KENTUCKY GENERAL ASSEMBLY FINAL LEGISLATIVE REPORT - 2019

**Kentucky's hospitals and health systems had a victorious legislative session with one-hundred percent of KHA's legislative priorities becoming law. In fact, each of KHA's priority bills passed both chambers unanimously and were signed into law by Governor Bevin!**

KHA was also successful in amending legislation initially filed with hospital concerns to remove those issues so that the final legislation had no adverse hospital impact. Finally, KHA worked to assure that no legislation harmful to hospitals advanced.

This success was made possible through the advocacy assistance and input of the Association's members. When hospitals combine their strength and collectively express their concerns to elected officials, more can be accomplished. It is critical for KHA and its members to advocate on behalf of hospitals and their patients. We are grateful for your action and participation.

This Kentucky General Assembly Final Legislative Report summarizes KHA's priority bills as well as other legislation enacted that KHA supported or which impact hospitals. Included with this report is the Senate and House Voting Record on KHA's priority bills and other health care legislation. The votes reveal how legislators voted on legislation that received a full vote in the Senate and/or House.

New laws from legislation that does not contain an emergency clause or a different, specified effective date will go into effect on June 27, 2019.

## WINS FOR KENTUCKY'S HOSPITALS

### ■ Medicaid Supplemental Payment Program

**HB 320 (Carney, co-sponsored by Hart, Massey, Pratt, Prunty and Reed)** is KHA's legislation to establish a Medicaid hospital supplemental payment program to bring payments up to cost for non-university Kentucky hospitals (since Kentucky's university hospitals have an existing, separate supplemental payment program). These new payments are needed to help replace federal funding that Kentucky hospitals are losing due to federal cuts in Medicare and Medicaid disproportionate share hospital (DSH) payments that have been subsidizing the gap between Medicaid payments and the actual cost of caring for Medicaid patients.

The Department for Medicaid Services (DMS) will determine the funding gap between Medicaid payments and actual cost, and provide an add-on supplemental payment to make up the difference. Supplemental payments will be made quarterly based on the number of Medicaid patients served by a hospital in the previous quarter according to paid claims data. The Medicaid managed care organizations (MCOs) will be given a supplemental capitation payment to cover the payments they will make to each hospital.

KHA was successful in repurposing existing hospital provider taxes that are no longer needed as matching funds for Medicaid DSH payments when federal Medicaid DSH cuts take effect. Under HB 320, these "excess DSH" taxes will be divided between university and non-university hospitals and redirected to support the new supplemental payments under HB 320 and existing supplemental payments to university hospitals. This was a key victory for hospitals because, in the absence of this change, existing law would have required that such excess DSH taxes revert to fund the general Medicaid program. However, the redirection of these taxes will not be sufficient to provide the full matching funds required for the new supplemental payments to non-university hospitals, so HB 320 establishes a new hospital assessment. Unlike the existing provider tax, the new assessment will only apply to non-university hospitals and will only raise the balance of the state match required to make the quarterly supplemental payments to those hospitals and to provide the Medicaid department with \$250,000 annually (which will generate \$500,000 when matched) to support the state's administrative costs for program implementation. The program is contingent on obtaining necessary fed-

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## WINS FOR KENTUCKY'S HOSPITALS - *continued*

eral approvals which KHA expects will be granted since the Kentucky program has been modeled after CMS-approved programs operating in other states.

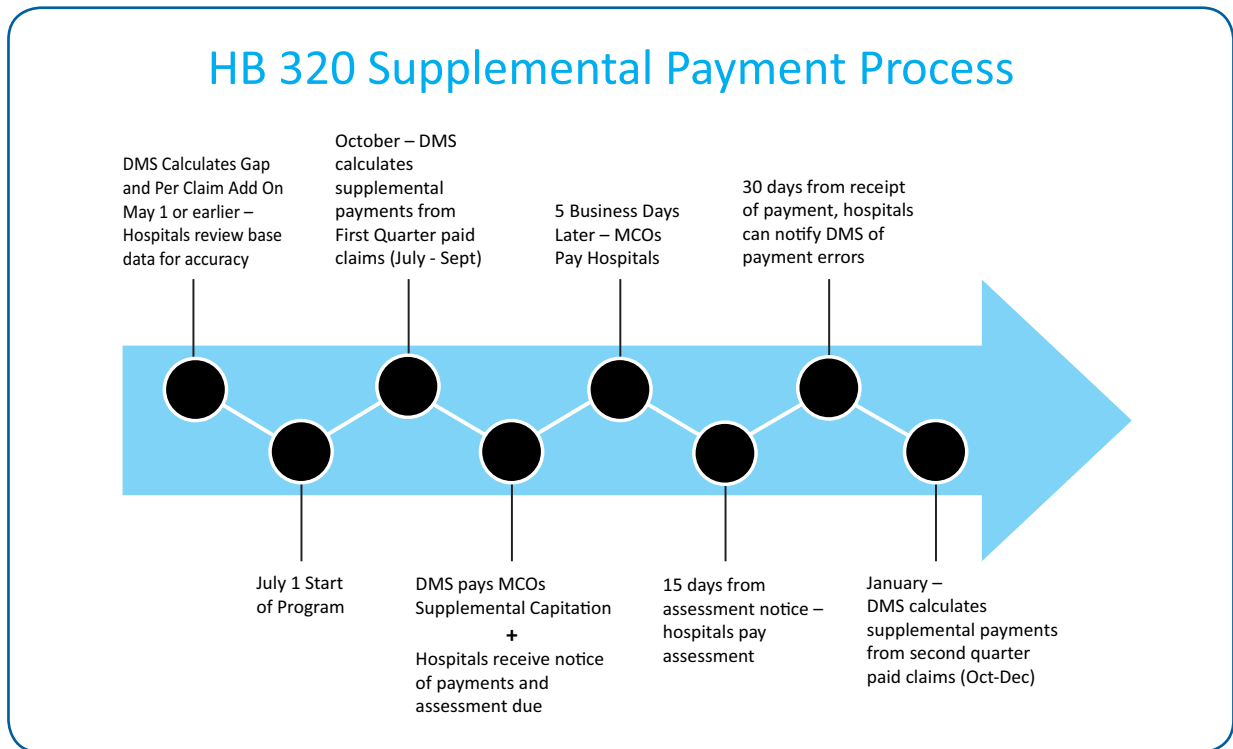
The process for making supplemental payments will work as follows:

- Annually and prior to the start of a state fiscal year, the Department for Medicaid Services (DMS) will determine the gap between costs and regular Medicaid payments for non-university Kentucky hospitals and out-of-state hospitals. This funding gap will be converted to a per-discharge amount that will be paid as a per-claim “add on” supplemental payment on future inpatient discharges.
  - The funding gap will be computed separately for county-owned hospitals and private hospitals for fee-for-service claims and on a combined basis for managed care claims.
  - It will also exclude claims for discharges at pediatric teaching hospitals and psychiatric access hospitals that already receive an enhanced Medicaid payment rate.
  - At least 30 days before the start of the fiscal year, DMS will provide each hospital with the opportunity to verify the base data used to calculate the fee-for-service and managed care spending gap. This is intended to assure that the Medicaid and MCO claims data being used are accurate (and tie to hospital data) in order to capture the full spending room available for supplemental payments.
- Each quarter, DMS will obtain a listing of the paid inpatient claims to non-university Kentucky hospitals for the quarter under fee-for-service and for each managed care organization (MCO). DMS will apply the per-claim “add on” to each claim and generate a listing of fee-for-service supplemental payments due and a listing for each MCO of the total amount of supplemental payments the MCO is to pay each hospital.
  - No add on will be made to paid claims for which a pediatric teaching hospital or a psychiatric access hospital also receives existing supplemental payments.
- DMS will provide each MCO with a supplemental capitation payment to cover the MCO’s quarterly supplemental payments to be paid to the hospitals in the quarter – this is a directed pass-through payment where all of the funds will flow through the MCOs to the hospitals. MCOs must pay the supplemental payments to hospitals within five business days of receiving the supplemental capitation payment from DMS.
- On the same day as the MCOs receive the supplemental capitation payments, each non-university Kentucky hospital will receive a notice of the hospital’s quarterly assessment, the date the assessment is due, how the assessment is calculated and the amount of the quarterly supplemental payments the hospital will receive from DMS and each MCO.
  - If a hospital believes there are errors in the data used to make a quarterly supplemental payment, within 30 days of receiving the payment, the hospital may notify DMS and provide documentation of the error. If DMS agrees that an error occurred, DMS is required to reconcile the error through an adjustment in the hospital’s next quarterly supplemental payment.
- Assessments are due in 15 days from the date of notice to the hospital – importantly, setting the assessment due date to be ten days after supplemental payments have been made will benefit all hospitals, and particularly vulnerable facilities, by assuring funds are available for facilities to pay the assessment on time.
- The assessment on non-university hospitals will be determined on a quarterly basis, since paid claims, supplemental payments and the state match required will vary each quarter. The assessment will be calculated on a per discharge basis, using the hospital’s total discharges reported on the Medicare cost report filed in the calendar year two years prior to the state fiscal year of the program. The department will first offset the excess DSH taxes attributable to non-university Kentucky hospitals to reduce the amount of the new assessment.
  - If a hospital is delinquent in payment of its assessment, DMS may delay or withhold a portion of the hospital’s supplemental payment. In order to ensure a smooth process, KHA is investigating the use of electronic funds transfer for hospitals to receive and make payment of their assessments.
  - A non-state government-owned hospital may use an IGT to pay its assessment.
- The department must complete its required actions within the same quarter as all required information is received.

In addition, the legislation contains other important safeguards for hospitals. The assessment is restricted for use

solely to accomplish the inpatient reimbursement increases and any funds collected but not expended at the close of a fiscal year may not lapse or revert to the General Fund. HB 320 also prevents the department from adopting fee-for-service rate-setting methodology changes that result in rate reductions from policies in effect as of October 1, 2018, for acute care hospitals and July 1, 2019, for hospitals paid on a per diem basis, which would otherwise increase the funding gap and assessment on hospitals.

Read HB 320: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb320/bill.pdf>



## ■ Bundling of MCO Denials for External Review

**SB 149 (Meredith)** is KHA’s legislation to permit providers to bundle like Medicaid managed care organization (MCO) denials in a single appeal under the existing process, which affords providers an independent external review of MCO denials of payment. This legislation was needed because the administrative regulations implementing Senate Bill 20, which established the independent external review process, fail to allow providers to bundle like MCO denials. Currently, if an MCO applies the same policy to deny 100 claims for the same reason, a provider must file 100 individual appeals. This is a costly process and deters providers, especially smaller providers with limited resources, from appealing. Through seven years of monthly meetings between hospitals and the MCOs to address claim payment and denial issues, it has become apparent that frequently there are MCO claim denials that affect many Medicaid enrollees in a like manner. It is illogical and unnecessary to require potentially hundreds of individual, separate appeals when each denial is due to a single, common issue of policy or claims handling by an MCO. SB 149 will promote an expeditious process, consistency in decisions and reduced administrative costs for both providers and the state, since the state pays their external review organization for each review they perform. Since this legislation benefits all providers, KHA was joined by eight other provider organizations in urging its adoption and signature by the Governor.

Read SB 149: [https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb149/orig\\_bill.pdf](https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb149/orig_bill.pdf)

## ■ Credentialing

**SB 110 (Meredith)** is KHA’s legislation that supports our establishment of a provider credentialing program to expedite credentialing for Medicaid participation. It removes an unintended restriction to give any provider the option to use the KHA credentialing service. Lengthy delays in MCO credentialing have been a pain point for the membership. Last year, legislation passed requiring the state to select a designated credentialing verification organization (CVO) but also allowed statewide trade associations to perform credentialing under a delegated arrangement with one or more MCOs, and KHA has qualified under this provision to operate a Medicaid credentialing service. However, the existing law inappropriately limited trade associations to perform credentialing only for providers associated with their mem-

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bers. SB 110 eliminates this restriction which will allow KHA to perform credentialing for any provider which chooses to use our service and, thereby, creates efficiencies for both MCOs and KHA. SB 110 was also amended in the Senate to make clarifications requested by the Cabinet pertaining to Medicaid enrollment. Under the Cabinet's amendments, the department will retain the enrollment function and must complete enrollment within 60 days (as opposed to 30 days for credentialing) from their receipt of a clean enrollment application. The cabinet is permitted to exceed this timeframe due to delays caused by external entities, including the requirement to perform heightened screening activities of certain entities as required by CMS. The legislation also encourages all state licensure boards to provide licensure information electronically to the cabinet and to all credentialing verification organizations, including KHA.

Read SB 110: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb110/bill.pdf>

### ■ Medical Licensure Compact

**SB 22 (Alvarado)** is one of KHA's legislative priority bills that authorizes Kentucky to join the interstate medical licensure compact. In doing so, physicians with an unrestricted license, who are located in another state that is part of the compact and who are board certified with no disciplinary action, may obtain a Kentucky license through an expedited process. The compact is overseen and administered by an Interstate Commission where each member state has two voting representatives. Member licensure boards are required to share complaint or disciplinary information; and, if a license granted to a physician by their state of principal license is revoked, surrendered, relinquished or suspended, all licenses issued to the physician by all member boards must be automatically placed on the same status. If a license granted to a physician by a member board is revoked, surrendered, relinquished or suspended, then any licenses issued to the physician by any other member boards are to be automatically suspended for 90 days to permit the member board to investigate under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license prior to completion of the 90-day period consistent with the Medical Practice Act of that state. KHA strongly supported passage of this legislation to increase access to health care for people in rural and underserved areas by allowing patients and hospitals to more easily consult medical experts through the use of telemedicine technology.

Prior to SB 22 receiving its final vote in the House of Representatives, a floor amendment was filed to add the contents of SB 132 to the bill. SB 132, which did not advance out of the Senate, proposed to eliminate the licensure requirement for an APRN to have a collaborative agreement with a physician to prescribe controlled substances (CAPA-CS) after four years and if their license was in good standing. While the sponsor agreed to withdraw this amendment, which cleared SB 22 for final passage, during the final vote many legislators rose to express their support for the position of the nurse practitioners and displeasure with physicians relative to this issue. KHA has committed to legislative leadership to meet with the Kentucky Coalition of Nurse Practitioners and Nurse Midwives soon after the end of the legislative session to work on compromise legislation.

Read SB 22: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb22/bill.pdf>

## HEALTH CARE LEGISLATION SUPPORTED BY KHA WHICH PASSED

### ■ Prior Authorization

**SB54 (Alvarado)** is legislation that updates Kentucky's laws on prior authorization, and contains many positive features for health care providers, patients and hospitals. These changes will cover commercial insurers as well as the Medicaid MCOs and include:

#### ● Prior Authorization for Medication

- Insurers will be required to have a process to receive requests and provide prior authorization decisions electronically
- A prior authorization for a drug prescribed to an individual with a condition that requires ongoing medication therapy will now be valid for 1 year (or the last day of coverage under the person's health benefit plan) and cover any change in dosage during the period of prior authorization. Except for palliative care patients, the 12-month prior authorization period will not apply for non-maintenance drugs, medications that have a typical treatment period of less than 12 months or where the medical evidence does not support a 12-month approval and opioid analgesics or benzodiazepines.

- **Improvement of timeframes for insurers to issue prior authorization decisions**
  - Urgent decisions must be rendered in 24 hours after obtaining all necessary information
  - Non-urgent decisions must be rendered in five days of obtaining all necessary information – this is an improvement as current law allows 14 days for commercial insurers to issue non-urgent decisions (MCOs are given 48 hours per their state contract)
  - Necessary information is limited to results of face-to-face clinical evaluations, a second opinion that may be required and other information determined by the Department of Insurance necessary to making a utilization review determination
- **Requirement for insurers to use a physician in the same or similar specialty and subspecialty as the ordering provider to conduct utilization review services when possible**

**KHA worked with Senator Alvarado to include additional provisions to address some of the most concerning practices of the Medicaid MCOs identified by the KHA Hospital Reimbursement Committee. These will impact all insurers, not just MCOs, and include:**

- **Improved Transparency**
  - Insurers must post on their public websites their written utilization review procedures, the list of services and codes for which preauthorization required, including where preauthorization is performed by a vendor under contract with the insurer, along with the preauthorization effective date or dates and the termination date or dates for each service or code. Since the MCOs often use multiple vendors to perform preauthorization of different services, which is difficult to track, this assures that providers can obtain a complete list of preauthorization requirements in one location with effective dates to match against their date of service to guard against inappropriate denials.
  - An insurer is prohibited from denying a claim for failure to obtain preauthorization if the requirement was not in effect on the date of service on the claim
- **Births and NICU Care**
  - Insurers may not require prior authorization for births or the inception of neonatal intensive care services
  - Insurers may not condition claim payment on their receipt of notice of a birth or the inception of neonatal intensive care services – since MCOs often attempt to require that hospitals provide notice of these activities rather than authorization, this assures that a claim cannot be denied for failure to provide such notice.
- **Coverage of Supplies**
  - Unless otherwise specified in a provider’s contract, an insurer shall not deem as incidental or deny supplies that are routinely used as part of a procedure when the procedure has either been preauthorized or preauthorization was not required. This will curtail the practice where some MCOs are denying claims for failure of a hospital to obtain preauthorization for a supply needed to perform the procedure when the procedure itself did not require authorization.

**SB 54 takes effect on January 1, 2020.**

Read SB 54: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb54/bill.pdf>

## ■ **Cancer Screening Coverage**

**SB 30 (Alvarado)** is legislation that will require insurers, when they issue or renew plans, to cover genetic testing for cancer if the recommendation for testing is consistent with genetic testing guidelines published by the National Comprehensive Cancer Network and the test is recommended by a physician, physician assistant or a genetic counselor. Such coverage will not be subject to a deductible, coinsurance or any other cost sharing and will be covered at the plan’s average in-network rate for out-of-network providers or laboratories if no in-network providers are available. SB 30 also amends existing law that already requires insurance coverage for colorectal cancer examinations as recommended by American Cancer Society Guidelines. Specifically, this legislation reduces the age from 50 to 45 years old for coverage of colorectal cancer examinations. This legislation will help support early cancer detection to reduce the state’s high rate of cancer deaths.

**SB 30 takes effect on January 1, 2020.**

Read SB 30: [https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb30/orig\\_bill.pdf](https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb30/orig_bill.pdf)

## ■ Smoke-Free Schools

**HB 11 (Moser)** will prohibit the use of tobacco products (including alternative nicotine and vapor products) by students, school personnel and visitors in schools, school vehicles and on school properties. Use of these products is also prohibited for students on a school trip or school activity as well as for other individuals while in the presence of a student(s) while supervising or participating in such activities. By July 1, 2020, each local board of education must adopt written policies to put these restrictions in place, including the posting of signage. In order for HB 11 to pass, a provision was added to permit a local board of education to opt out of these requirements three years after the effective date of the act. KHA strongly supported the legislation as a means to reduce smoking rates among Kentucky's youth along with reducing exposure to secondhand smoke.

## OTHER HEALTH CARE LEGISLATION OF INTEREST THAT PASSED

### ■ Licensure of Certified Professional Midwives

**SB 84 (Buford, co-sponsored by Adams, Clark, Givens, Harper Angel, Hornback, Thomas, Wilson)** establishes a new licensure category for “certified professional midwives” (CPM) to be regulated under the Kentucky Board of Nursing. CPMs are not nurses, but have taken specified education and training and passed a national examination. Since many lay midwives are currently delivering home births in Kentucky without any oversight, this legislation will provide needed scrutiny over the actions of these individuals. KHA changed its position from opposition to neutral once the bill was amended to address high-risk births, informed consent and transfer agreements.

SB 84 will require the Kentucky Board of Nursing (KBN) to promulgate regulations to establish standards for CPM training programs, educational and competency requirements for licensure, statewide requirements for the transfer of care from a CPM to a hospital, provisions for disciplinary actions, licensure fees, requirements for patient informed consent, a list of medical tests that a CPM may order and a formulary of legend drugs that a CPM may administer limited to those for the safe conduct of pregnancy, labor and birth, and requirements for outcomes reporting to the Board. The Kentucky Organization of Nurse Leaders will have input into these regulations as a nurse service administrator, representing KONL, serves as a member of the KBN.

SB 84 creates a CPM Advisory Council to advise the Board on its regulations to implement the statute. The Advisory Council will be comprised of nine voting members, the majority of which shall be physicians and nurses – two APRN nurse midwives, two obstetricians and one neonatal care provider. The law also creates a time-limited Transfer Guidelines Workgroup to develop statewide guidelines that CPMs must follow when transferring a patient to a hospital. The guidelines are to address the process of transfer of care from a CPM to a hospital, including the timely transmission of all necessary information required to satisfactorily care for a mother or newborn requiring transfer. The Transfer Guidelines Workgroup is comprised of eight voting members, two of which will be appointed by KHA and two to be appointed by the Kentucky Medical Association (KMA). The Workgroup is to submit its requirements – to be agreed to unanimously – within one year of the effective date of the act, and then the group will cease to exist. While the statute requires CPMs to follow the transfer guidelines and hospitals must meet their EMTALA obligations, the law does not mandate any hospital to enter into a transfer agreement or collaborative agreement with a CPM.

SB 84 addresses the care of high-risk patients by requiring the Advisory Council to make recommendations to the KBN regarding regulations for the management of patients with medical conditions that preclude them from being considered at low risk of an adverse outcome. The regulations are required to address the process to facilitate collaboration, consultation and referral to a physician as well as a list of conditions or symptoms associated with a risk of harm with regulatory requirements for consultation, collaborative management or patient transfer. In recognition that it will take time for the Advisory Committee to develop such recommendations and for regulations to be adopted, the statute sets out specific requirements for patients with certain high-risk conditions. Specifically, until regulations are in place, the legislation requires a CPM to arrange for consultation and either collaboration or referral to a physician if the patient has one of 10 specific conditions (such as placenta previa, HIV infection, hypertension, pre-eclampsia) and any other condition that could threaten the life of the mother or fetus. Collaboration is defined as co-management by a physician and CPM, consultation is defined as a CPM directing a client to a physician for an opinion on management of a medical condition whereby a patient may refuse but the refusal would be documented by the physician and CPM, and referral is where the CPM arranges for a physician to assume primary management of the patient. Further, the statute requires a CPM to arrange for consultation and either collaboration or referral if the patient has had a prior C-section or other surgery resulting in a uterine scar, multifetal gestation, breech birth after 36 weeks gestation and history of severe shoulder dystocia.



The Board is required to issue regulations on informed consent, but the legislation mandates specific items which must be addressed. These include the CPM's education and training, the protocol for emergencies including transfer to a hospital, the benefits and risks of home birth, requirements for collaboration, consultation and referral to a physician and disclosure of malpractice insurance held by the CPM.

The bill's original immunity provisions for physicians, APRNs, EMS and hospital personnel collaborating with or accepting patient transfers from a CPM raised concerns with some legislators. Therefore, in the interest of passing the bill with the above described changes, KHA and hospital legal counsels worked to develop agreed upon immunity language which was adopted in the final bill to simply reflect current law such that health care professionals do not take on liability for negligent acts of a CPM and are only responsible for their own actions.

Read SB 84: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb84/bill.pdf>

## ■ Auto Insurance Fraud

**HB 151 (Fischer)** was supported by the auto insurance industry to reduce insurance fraud. It will require professional licensure boards to notify the Department of Insurance if they have knowledge of a fraudulent insurance act being committed by a licensee. The bill also increases the penalties for insurance fraud. The bill as originally filed, however, contained language imposing federal "Stark-like" self-referral language, which would have prohibited a hospital-employed physician from referring an injured patient covered by auto insurance to the hospital for further services and if such referral occurred, no payment would have been required and the provider could have faced suspension of their professional license. KHA worked with the bill sponsor to successfully amend the legislation to mitigate these issues. The final bill provides an exemption from the self-referral provisions for any licensed physician, osteopath, or podiatrist (KRS 311), emergency medical services personnel (KRS 311A), medical imaging professional (KRS 311B), chiropractor (KRS 312), dentist (KRS 313), registered nurse (KRS 314), respiratory care practitioner (KRS 314A), pharmacist (KRS 315), psychologist (KRS 319), occupational therapist (KRS 319A), prosthetist, orthotist and pedorthist (KRS 319B), optometrist (KRS 320), physical therapist (KRS 327) or medical laboratory that is enrolled in the Kentucky Medicaid program. This will essentially exempt all hospitals and their employed health care practitioners from the self-referral language and prohibition on payment.

Read HB 151: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb151/bill.pdf>

## ■ Certificate of Merit

**HB 429 (McCoy)** will require a claimant initiating litigation against a physician, surgeon, dentist or hospital for negligence or malpractice or against a long-term care facility to file a certificate of merit with the complaint in the court in which the action is commenced. A certificate of merit means an affidavit or declaration that the claimant has consulted with at least one expert as to the standard of care or negligence who believes there is reasonable basis to commence the action. An affidavit may be filed later (60 days after filing the litigation) if there was a lack of time to obtain the consultation before the statute of limitations would have run; however, no certificate of merit is required in the circumstances where three good faith efforts are made to contact three different experts but none of those experts would agree to a consultation so long as none gave an opinion that there was no reasonable basis for the action. Only one certificate of merit is required for an action even if more than one defendant has been named in the complaint and none is required where the claimant intends to rely solely on a cause of action where expert testimony is not required, such as lack of informed consent. Finally, if the claimant has requested their medical records and those records have not been produced, no certificate of merit is due until 90 days after the records have been produced. This bill became law without the Governor's signature.

Read HB 429: [https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb429/orig\\_bill.pdf](https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb429/orig_bill.pdf)

## ■ Non-Profit Tax Correction

**HB 354 (Rudy, co-sponsored by Bechler, Sheldon)** is legislation that makes corrections to changes in the tax code passed last year. Those changes applied state sales tax to admissions charged by nonprofit entities and adversely impacted hospital foundations and their charitable events. HB 354 corrects this by exempting from tax those admissions charged by nonprofit educational, charitable, religious institutions, civic, governmental or other nonprofit organizations as well as fundraising event sales by those organizations. Fundraising event sales would cover hospital charity auctions, but exclude sales related to the operation of a retail business including but not limited to thrift stores, bookstores, surplus property auctions, recycle and reuse stores or any ongoing operations in competition with for-profit retailers.

Read HB 354: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb354/bill.pdf>

## ■ Pharmacy

**HB 64 (Bentley)** will allow a pharmacist to dispense maintenance medication in emergency situations where an authorization cannot be readily obtained from the prescribing practitioner. This is limited to a 72-hour supply; however, more than a 72-hour supply may be dispensed if the standard unit of dispensing for the drug exceeds a 72-hour supply and the drug is used for insulin therapy or treatment of chronic respiratory disease. The Board of Pharmacy is directed to issue regulations to implement this statute.

Read HB 64: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb64/bill.pdf>

**HB 342 (Sheldon)** will require electronic prescribing by all practitioners for a controlled substance beginning January 1, 2021, unless the practitioner meets a specific exemption listed in the legislation. Exemptions include hospice patients, nursing facility residents, technology hardships, drugs that cannot be electronically prescribed including extemporaneous compounding, when a pharmacy is located in another state and when the prescriber and dispenser are the same entity.

Read HB 342: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb342/bill.pdf>

## ■ Emergency Medical Services

**HB 106 (Rothenburger, co-sponsored by Moser, Prunty, Wheatley)** is legislation that updates the terminology for emergency medical service practitioners, and includes new definitions for advanced practice paramedic and advanced EMTs. Advanced practice paramedics must validate competency through certification as a community paramedic, critical care paramedic, flight paramedic, tactical paramedic or wilderness paramedic. It also adds several new classes of EMS providers including Class IV ground ambulance providers that serve a restricted location, Class V mobile integrated health care programs (which do not transport patients and are operated by or in affiliation with a Class I ambulance service), Class VI medical first response providers (which provide basic or advanced life support services but do not transport patients), Class VII air ambulance providers and Class VII event medicine providers (which also do not transport patients). These new categories of EMS provider types will help integrate EMS care into the health care system, especially the community paramedic, who can help hospitals control readmissions by performing in-home follow up assessments. The bill also reduced the Board of EMS from 18 to 13 members, but retains one hospital administrator selected from KHA nominees.

Read HB 106: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb106/bill.pdf>

## ■ Medicaid Payment of Durable Medical Equipment

**HB 224 (Moser, co-sponsored by Sheldon, Bentley, Bowling, Graviss, Prunty, Thomas, Willner)** mandates specific reimbursement for durable medical equipment (DME) under Medicaid. HB 224 requires the Department for Medicaid Services (DMS) to reimburse DME supplies at no less than 90% of the state Medicaid DME fee schedule and also requires that same level of reimbursement to be paid by the Medicaid managed care organizations (MCOs). MCOs must also cover the same quantities of DME supplies and equipment as under fee-for-service and follow the same timeframe for timely filing of claims. This establishes a precedent by removing the authority for MCOs to negotiate rates as well as apply their own utilization review requirements which could limit quantities of DME supplies and equipment below fee-for-service coverage levels. A fiscal note on the bill indicated that the legislation would increase Medicaid expenditures by \$30.2 million, of which \$6 million would be increased General Fund dollars. This bill became law without the Governor's signature.

Read HB 224: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb224/bill.pdf>

## ■ Patient Test Results for HIV

**HB 439 (Moser)** helps hospitals better manage the process of providing HIV test results to patients. Current law requires the physician or APRN who orders the test, or the attending physician, to inform the patient of the results. HB 439 will allow a designee to provide the results to the patient, and if the results are positive, the designee may also provide a referral to other health care services and provide information and counseling to the patient. This legislation will give hospitals more flexibility to use other staff to contact the patient and provide this information.

Read HB 439: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb439/bill.pdf>

## ■ Naloxone

**HB 470 (McCoy, co-sponsored by Osborne)** allows a pharmacist to dispense naloxone to any person or agency who provides training on its administration to the public as part of a harm reduction program.

Read HB 470: [https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb470/orig\\_bill.pdf](https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb470/orig_bill.pdf)

## ■ Substance Use Disorder

**HB 513 (Tate, co-sponsored by Sheldon)** updates existing laws to state-of-the-art terminology by replacing references to alcohol and other drug abuse with “substance use disorder” and updates references to the Department for Behavioral Health, Developmental and Intellectual Disabilities within the Cabinet for Health and Family Services. It also gives the Cabinet authority to suspend the license of a substance use disorder treatment program if they believe there is an immediate threat to public health and safety, and sets out procedures for an emergency hearing for persons required to comply with such an emergency order.

Read HB 513: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/hb513/bill.pdf>

## ■ Rare Diseases

**SB 16 (Adams, co-sponsored by Embry)** establishes the Kentucky Rare Disease Advisory Council to advise the legislature, state agencies and private institutions on rare diseases, which are typically defined as a disease that affects fewer than 200,000 people. The Council is charged with conducting research and identifying best practices for rare disease care in collaboration with the state’s medical schools and hospitals that provide such care, and fostering improved cooperation regarding research, diagnosis and treatment.

Read SB 16: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb16/bill.pdf>

## ■ Pregnancy Related Accommodations

**SB 18 (Kerr, co-sponsored by Adams, Embry, Harper Angel, Hornback, McGarvey, Meredith, Schroder, Thomas, Webb)** impacts hospitals as it requires employers with 15 or more employees to provide reasonable accommodations for employees related to pregnancy, childbirth or related medical conditions (which is defined as including expressing breast milk for nursing a child). Such accommodations may include more frequent or longer breaks, time off to recover from childbirth, acquisition or modification of equipment, appropriate seating, temporary transfer to a less strenuous or less hazardous position, job restructuring, light duty, modified work schedule and private space that is not a bathroom for expressing breast milk. Employers are required to comply unless they can demonstrate the accommodation would impose an undue hardship on the employer’s business. Employers are required to provide written notice of such accommodations for new employees and to existing employees within 30 days after the effective date of this Act as well as post a sign with this information in an area accessible to employees.

Read SB 18: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb18/bill.pdf>

## ■ Abortion

**SB 50 (Smith)** will require state reporting of certain medications, including the use of pitocin, when the intent is to induce an abortion as defined in KRS 311.720. The legislation as originally filed could have created unintended consequences for reporting by hospitals that administer pitocin. The final legislation addresses that concern by limiting the reporting requirement only for actions to terminate the pregnancy of a woman known to be pregnant with the intent to cause fetal death.

Read SB 50: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb50/bill.pdf>

## ■ Palliative Care

**SB 65 (Adams)** establishes a Palliative Care Interdisciplinary Advisory Council attached to the Cabinet for Health and Family Services to advise the state and Cabinet on matters related to palliative care. The Council will advise the Cabinet on the Palliative Care Consumer and Professional Information and Education Program, which requires the cabinet to publish on its website information and resources about palliative care for the public, health care providers and health facilities. SB 65 does not require hospitals to refer patients to palliative care services, which has been proposed in prior legislative proposals. The legislation also provides an exemption for patients of a certified community-based palliative care program from existing laws which limit a practitioner from issuing a prescription for more than a three-day supply of a Schedule II controlled substance to treat acute pain.

Read SB 65: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb65/bill.pdf>

## ■ Organ Donor Registration

**SB 77 (Adams)** expands opportunities for individuals to become an organ donor through the state’s single sign-on system as well as when individuals apply for or renew a state identification card. These changes take effect on January 1, 2020.

Read SB 77: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb77/bill.pdf>

## ■ Diabetes Care for Medicaid Beneficiaries

**SJR 7 (Alvarado)** is a resolution that directs the Department for Medicaid Services (DMS) to study the potential impacts of implementing programs similar to the Kentucky Employee Health Plan's Diabetes Value Benefit Plan and Diabetes Prevention Program for Medicaid beneficiaries which have shown cost savings and positive results in improving diabetes care. The Department is required to submit a written report of its findings to the Interim Joint Committee on Health and Welfare and Family Services by November 1, 2019.

Read SJR 7: <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sjr7/bill.pdf>

## LEGISLATION NOT ADVANCING

*The following bills did not advance in the 2019 session but many will be worked on during the interim, and KHA expects them to be refiled in 2020.*

## ■ Auto Insurance Payment for Medical Care

**SB 137 (Girdler)** proposed to revise payment for medical expenses under PIP to set payment at the workers' compensation fee schedule. However, KHA worked with the bill sponsor in the interim and was able to obtain an exemption from payment at the workers' compensation fee schedule for all inpatient auto claims and all outpatient auto claims which had an emergency department charge (which represents 83% of all outpatient claims billed to auto insurance). During the interim, the Department of Insurance (DOI) conducted a study, using sample data, of the impact of applying the workers' compensation fee schedule to hospital auto claims. KHA applied the DOI results to all hospital claims where auto insurance was listed as primary to demonstrate that payment at the workers' compensation fee schedule would reduce hospital payments by \$216 million. This negative financial impact, coupled with hospitals' EMTALA obligation for patients presenting to an ED, support the hospital exemptions provided in the bill. In order to obtain these exemptions, KHA agreed to a compromise where the remaining 17% of outpatient services billed to auto insurance without an ED charge would be paid at the workers' compensation fee schedule. The bill did not advance due to opposition from other interested groups.

## ■ Ambulatory Facility Data Reporting

**SB 181(Mills)** was a Cabinet for Health and Family Services clean-up bill of out-of-date statutes, but it included a change supported by KHA. The bill fixed an unintended error made by HB 444 from the 2018 session to restore mandated data reporting for certain outpatient facilities that were exempted from state licensure. KHA supported this bill because data from all health facilities is needed in order to determine trends in utilization and for price transparency.

## ■ Certificate of Need

**SB 182 (Kerr)** contained revisions to a variety of statutes involving long-term care facilities but also to certificate of need (CON). This legislation eliminated the list of CON-exempt services and instead listed the facilities and services for which a CON is required for licensure. Anything not on the list would, therefore, be CON exempt. The bill retained CON for the core hospital services of beds (Acute, Psychiatric, Chemical Dependency, NICU and Rehabilitation) as well as for ambulatory surgery centers, cardiac catheterization, freestanding EDs, megavoltage radiation equipment, open heart surgery, organ transplantation and PET. It also retained CON for birthing centers, ground ambulance and home health. Services previously subject to CON which would have been exempt include MRI, partial hospitalization, PRTF I and II, and residential SUD facilities with more than 16 beds. Although these services would not require a CON, they would have continued to be subject to licensure. The Cabinet's rationale for removing partial hospitalization from CON is to conform to regulations that are being amended to license SUD services, which will allow behavioral health service organizations (BHSOs) to offer this service as well as community mental health centers which are already CON exempt. The bill also made considerable positive changes for hospitals to the law governing PRTF I and II facilities by removing the prohibition on locating a PRTF I on a hospital campus, removing the limitations on the number of beds in a PRTF I (28 bed units) and PRTF II (50 beds/facility), as well as onerous PRTF II staffing standards. KHA's Psychiatric and Chemical Dependency Forum has raised concerns with these requirements as barriers to the development of these needed services. KHA worked with the Cabinet on several amendments to the CON changes which were reflected in the bill. The Cabinet has indicated that passing the CON changes will be a priority during the 2020 session.

## ■ Surprise Billing

**SB 24 (Alvarado)** would have established an independent dispute resolution procedure for disputed out-of-network practitioner and facility charges and balance billing whereby a designated reviewer would select the amount to be paid from a proposed binding amount submitted by each party. Among the factors the reviewer would have considered was the usual and customary rates at the 80th percentile of similar services in the geographic area. The bill would have also required health facilities to post on their website the health benefit plans the facility participates in along with contact information for hospital-based providers, and provide standard information at the time of registration and admission for a non-emergency service that hospital-based providers may not be in the same network as the facility. Practitioners would have been required to notify patients about which plans they participate in and provide charge estimates upon request. KHA worked with the sponsor to explain the administrative burden on hospitals created by the legislation to post all plans in which they participate, including direct employer contracts. KHA and its members believe patients should contact their insurer to obtain information on which providers are in-network for that patient's health plan and insurers should be required to maintain current, up-to-date online provider directories and provide cost estimates.

## ■ Medical Marijuana

**HB 136 (Onge)** would have legalized medical marijuana and established provisions to regulate its possession, cultivation and sale. Kentucky hospital physician leaders have expressed there is no scientific evidence to support the benefits of medical marijuana as a standard of care and, in the absence of such evidence, legalization could exacerbate the state's existing substance abuse problems.

**HCR 121(Moser)** would have created a Medicinal Marijuana Task Force to study and make recommendations related to the medicinal use of marijuana in the state.

## ■ Prescriptive Authority

**SB 132 (Hornback, co-sponsored by Adams, Buford, Embry, Girdler, McGarvey, Thomas, Turner)** would have removed the licensure requirement for an APRN to have a collaborative agreement with a physician to prescribe controlled substances (CAPA-CS) after four years if their license is in good standing. The elimination of the collaborative agreement would have only applied to licensure and would not have restricted hospitals from having their own requirements for prescribing within a hospital.

**HB 440 (Moser)** would have strengthened the collaborative agreement (CAPA-CS) requirement for an APRN to prescribe controlled substances. HB 440 would have required the CAPA-CS for an APRN to prescribe Schedule II-V controlled substances to be developed by the Kentucky Board of Medical Licensure; certain duties of a collaborating physician that included chart review, and an in-person patient evaluation at least annually for those receiving controlled substance prescriptions by the APRN; review of KASPER data for each patient receiving a controlled substance under the agreement; and quarterly meetings with the APRN to discuss the relationship. Since this would have been a requirement for a licensed APRN to prescribe in any setting, it would have impacted hospitals that permit an APRN to prescribe in a hospital or hospital-owned facility.

**HB 93 (Elliott)** would have granted prescription authority for physician assistants (PAs) for controlled substances; set out training required; permitted prescription and administration of non-narcotic Schedule II and all Schedules III - V controlled substances as delegated but excluding prescription of opioids; required Board approval and registration with KASPER; limited prescriptions for Schedules II and III to a 30-day supply without refill and limited Schedules IV and V to the original prescription and a six-month refill; and limited prescriptions for Diazepam, Clonazepam, Lorazepam, Alprazolam and Carisoprodol to 30 days without refill.

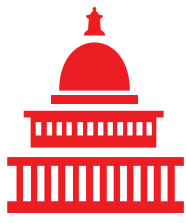
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# KENTUCKY - HOUSE

Legislator Voting Record on Kentucky Hospital Association  
Bills for the 2019 Kentucky General Assembly Session

Y - Yes Vote  
N - No Vote  
X - Did Not Vote



| KHA Position                 |           | SUPPORT   | SUPPORT  | SUPPORT                                   | NEUTRAL  | SUPPORT   | SUPPORT  | SUPPORT   | SUPPORT                                  | SUPPORT   | SUPPORT   | NEUTRAL                         |
|------------------------------|-----------|---|--|---|--|---|--|---|--|---|---|---------------------------------|
| Legislator                   | % Support | SB 22<br>Medical Licensure<br>Compact<br>Passed | SB 30<br>Cancer Prevention<br>Screening and Genetic<br>Testing<br>Passed | SB 54<br>Prior<br>Authorization<br>Passed | SB 84<br>Licensed Certified<br>Professional Midwives<br>Passed | SB 110<br>Medicaid Credentialing<br>of Health Care<br>Providers<br>Passed | SB 149<br>Bundling of Medicaid<br>MCOs Denials<br>Passed | House Did Not<br>Vote<br>SB 181<br>Cabinet Operations | HB 11<br>Smoke-Free<br>Schools<br>Passed | Initial Vote HB 320<br>Hospital Rate<br>Improvement Program<br>Passed | Final Vote HB 320<br>Hospital Rate<br>Improvement Program<br>Passed | HB 429<br>Tort Reform<br>Passed |
| Adkins, Rocky (D-99)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Bechler, Lynn (R-4)          | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Bentley, Danny (R-98)        | 100%      | Y   | Y  | Y   | X  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Blanton, John (R-92)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Bojanowski, Tina (R-32)      | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | X                               |
| Booker, Charles (D-43)       | 100%      | X   | X  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Bowling, Adam (R-87)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Branham Clark, Terri (D-100) | 75%       | N   | N  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Bratcher, Kevin (R-29)       | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Brenda, R. Travis (R-71)     | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Bridges, Randy (R-3)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Brown Jr., George (D-77)     | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Burch, Tom (D-30)            | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | X   | N                               |
| Cantrell, McKenzie (D-38)    | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Carney, John "Bam" (R-51)    | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Donohue, Jeffery (D-37)      | 75%       | N   | N  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Dossett, Myron (R-9)         | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| DuPlessis, Jim (R-25)        | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | X                               |
| Elkins, Larry (R-5)          | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Elliott, Daniel (R-54)       | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Fischer, Joseph (R-68)       | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Flood, Kelly (D-75)          | 75%       | N   | N  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Frazier, Deanna (R-81)       | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Freeland, Chris (R-6)        | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Fugate, Chris (R-84)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Gentry, Al (D-46)            | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Glenn, Jim (D-13)            | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Goforth, Robert (R-89)       | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Gooch Jr., Jim (R-12)        | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Graham, Derrick (D-57)       | 83%       | X   | X  | Y   | Y  | Y   | Y  | X   | Y  | Y   | N   | N                               |
| Graviss, Joe (D-56)          | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Hale, David (R-74)           | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Harris, Chris (D-93)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Hart, Mark (R-78)            | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Hatton, Angie (D-94)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Heath, Richard (R-2)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Hinkle, Kathy (D-96)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Hoover, Jeff (R-83)          | 100%      | Y   | Y  | Y   | X  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Howard, Cluster (D-91)       | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Huff, Regina (R-82)          | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Huff, Thomas (R-49)          | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Jenkins, Joni (D-44)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Keene, Dennis (D-67)         | 75%       | Y   | X  | Y   | Y  | X   | X  | X   | Y  | X   | N   | N                               |
| King, Kim (R-55)             | 88%       | Y   | Y  | Y   | N  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Koch, Matthew (R-72)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Koenig, Adam (R-69)          | 75%       | Y   | N  | N   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Kulkarni, Nima (D-40)        | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |

**KENTUCKY - HOUSE** (continued)

Y - Yes Vote N - No Vote X - Did Not Vote

| KHA Position                   |           | SUPPORT   | SUPPORT  | SUPPORT                                   | NEUTRAL  | SUPPORT   | SUPPORT  | SUPPORT   | SUPPORT                                  | SUPPORT   | SUPPORT   | NEUTRAL                         |
|--------------------------------|-----------|---|--|---|--|---|--|---|--|---|---|---------------------------------|
| Legislator                     | % Support | SB 22<br>Medical Licensure<br>Compact<br>Passed | SB 30<br>Cancer Prevention<br>Screening and Genetic<br>Testing<br>Passed | SB 54<br>Prior<br>Authorization<br>Passed | SB 84<br>Licensed Certified<br>Professional Midwives<br>Passed | SB 110<br>Medicaid Credentialing<br>of Health Care<br>Providers<br>Passed | SB 149<br>Bundling of Medicaid<br>MCOs Denials<br>Passed | House Did Not<br>Vote<br>SB 181<br>Cabinet Operations | HB 11<br>Smoke-Free<br>Schools<br>Passed | Initial Vote HB 320<br>Hospital Rate<br>Improvement Program<br>Passed | Final Vote HB 320<br>Hospital Rate<br>Improvement Program<br>Passed | HB 429<br>Tort Reform<br>Passed |
| Lee, Stan (R-45)               | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Lewis, Derek (R-90)            | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Lewis, Scott (R-14)            | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Maddox, Savannah (R-61)        | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Marzian, Mary Lou (D-34)       | 88%       | N   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Massey, C. Ed (R-66)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| McCool, Bobby (R-97)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| McCoy, Chad (R-50)             | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Meade, David (R-80)            | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Meeks, Reginald (D-42)         | 86%       | X   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | N   | N                               |
| Meredith, Michael (R-19)       | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Meyer, Russ (D-39)             | 100%      | X   | Y  | X   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Miles, Suzanne (R-7)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Miller, Charles (D-28)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Miller, Jerry (R-36)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Minter, Patti (D-20)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Moore, Tim (R-18)              | 100%      | Y   | Y  | X   | Y  | Y   | Y  | X   | Y  | Y   | Y   | X                               |
| Moser, Kimberly Poore (R-64)   | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Nemes, Jason (R-33)            | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | X   | Y                               |
| Osborne, David (R-59)          | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Palumbo, Ruth Ann (D-76)       | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Petrie, Jason (R-16)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Pratt, Phillip (R-62)          | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Prunty, Melinda Gibbons (R-15) | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Rand, Rick (D-47)              | 100%      | X   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | X   | X                               |
| Raymond, Josie (D-31)          | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | X                               |
| Reed, Brandon (R-24)           | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Riley, Steve (R-23)            | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | X   | Y   | Y                               |
| Rothenburger, Rob (R-58)       | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Rowland, Bart (R-21)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | X   | Y   | X                               |
| Rudy, Steven (R-1)             | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Santoro, Sal (R-60)            | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Schamore, Dean (D-10)          | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Scott, Attica (D-41)           | 88%       | N   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Sheldon, Steve (R-17)          | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Sims Jr., John (D-70)          | 100%      | X   | Y  | Y   | Y  | Y   | Y  | X   | Y  | X   | Y   | Y                               |
| Sorolis, Maria (D-48)          | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| St. Onge, Diane (R-63)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | X   | Y   | Y                               |
| Stevenson, Cherlynn (D-88)     | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Steward III, Jim (R-86)        | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Stone, Wilson (D-22)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Tackett-Laferty, Ashley (D-95) | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Tate, Nancy (R-27)             | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Thomas, Walker (R-8)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Tipton, James (R-53)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Turner, Tommy (R-85)           | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | N  | Y   | Y   | Y                               |
| Upchurch, Ken (R-52)           | 100%      | X   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Webber, Russell (R-26)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |
| Westrom, Susan (D-79)          | 100%      | Y   | Y  | Y   | X  | Y   | Y  | X   | Y  | Y   | Y   | X                               |
| Wheatley, Buddy (D-65)         | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Wiederstein, Rob (D-11)        | 88%       | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | N   | Y                               |
| Willner, Lisa (D-35)           | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | N                               |
| Yates, Les (R-73)              | 100%      | Y   | Y  | Y   | Y  | Y   | Y  | X   | Y  | Y   | Y   | Y                               |



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