

1 AN ACT relating to coverage for the care of children.

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

3 ➔Section 1. KRS 304.17A-258 is amended to read as follows:

4 (1) **As used in**~~[For purposes of]~~ this section:

5 (a) "Therapeutic food, formulas, and supplements" means products intended for  
6 the dietary treatment of inborn errors of metabolism or genetic conditions,  
7 including but not limited to eosinophilic disorders, food protein allergies, food  
8 protein-induced enterocolitis syndrome, mitochondrial disease, and short  
9 bowel disorders, under the direction of a physician, and includes amino acid-  
10 based elemental formula and the use of vitamin and nutritional supplements  
11 such as coenzyme Q10, vitamin E, vitamin C, vitamin B1, vitamin B2,  
12 vitamin K1, and L-carnitine;

13 (b) "Low-protein modified food" means a product formulated to have less than  
14 one (1) gram of protein per serving and intended for the dietary treatment of  
15 inborn errors of metabolism or genetic conditions under the direction of a  
16 physician; and

17 (c) "Amino acid-based elemental formula" means a product intended for the  
18 diagnosis and dietary treatment of eosinophilic disorders, food protein  
19 allergies, food protein-induced enterocolitis, and short **bowel**~~[bowel]~~  
20 syndrome under the direction of a physician.

21 (2) **(a)** A health benefit plan that provides prescription drug coverage shall include in  
22 that coverage therapeutic food, formulas, supplements, and low-protein  
23 modified food products for the treatment of inborn errors of metabolism or  
24 genetic conditions, including those that are compounded, if the therapeutic  
25 food, formulas, supplements, and low-protein modified food products are  
26 obtained for the therapeutic treatment of inborn errors of metabolism or  
27 genetic conditions, including but not limited to mitochondrial disease, under

1 the direction of a physician.

2 **(b) Except as provided in subsection (4) of this section,** coverage under this  
 3 subsection may be subject, for each plan year, to a cap of twenty-five thousand  
 4 dollars (\$25,000) for therapeutic food, formulas, and supplements and a  
 5 separate cap for each plan year of four thousand dollars (\$4,000) ~~for~~ low-  
 6 protein modified foods. ~~[Each cap shall be subject to annual inflation~~  
 7 ~~adjustments based on the consumer price index.]~~

8 **(c)** Coverage under this ~~subsection~~ shall not be denied because two (2)  
 9 or more supplements are compounded.

10 (3) **(a) To the extent that coverage is not provided under subsection (2) of this**  
 11 **section or KRS 304.17A-139, a health benefit plan shall provide coverage**  
 12 **for enteral infant and baby formulas prescribed by a physician in a written**  
 13 **order, which states that the formula:**

14 **1. Is medically necessary; and**

15 **2. Has been proven effective as a disease-specific treatment regimen** ~~[The~~  
 16 ~~requirements of this section shall apply to all health benefit plans issued~~  
 17 ~~or renewed on and after January 1, 2017].~~

18 **(b) Except as provided in subsection (4) of this section, coverage under this**  
 19 **subsection may be subject to, for each plan year, a cap of three thousand**  
 20 **dollars (\$3,000).**

21 (4) **Any cap imposed on the coverages required under subsections (2) and (3) of this**  
 22 **section shall be subject to annual inflation adjustments based on the**  
 23 **nonseasonally adjusted annual average Consumer Price Index for All Urban**  
 24 **Consumers (CPI-U), U.S. City Average, All Items, as published by the United**  
 25 **States Bureau of Labor Statistics.** ~~[Nothing in this section or KRS 205.560,~~  
 26 ~~213.141, or 214.155 shall be construed to require a health benefit plan to provide~~  
 27 ~~coverage for therapeutic foods, formulas, supplements, or low-protein modified~~

1 ~~food for the treatment of lactose intolerance, protein intolerance, food allergy, food~~  
 2 ~~sensitivity, or any other condition or disease that is not an inborn error of~~  
 3 ~~metabolism or genetic condition.]~~

4 ➔SECTION 2. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304  
 5 IS CREATED TO READ AS FOLLOWS:

6 **(1) (a) A health benefit plan shall provide, in conjunction with each birth,**  
 7 **coverage for:**

8 **1. Renting or purchasing breastfeeding equipment; and**

9 **2. Comprehensive lactation support and counseling by a trained health**  
 10 **care professional during pregnancy and in the postpartum period.**

11 **(b) A health benefit plan shall not require a prescription or order from a health**  
 12 **care provider in order for a covered person to be entitled to the coverage**  
 13 **provided under this section.**

14 **(2) The coverage required under this section shall not be subject to any cost-sharing**  
 15 **requirement, including any copayment, coinsurance, or deductible.**

16 ➔Section 3. KRS 205.522 (Effective January 1, 2023) is amended to read as  
 17 follows:

18 (1) The Department for Medicaid Services and any managed care organization  
 19 contracted to provide Medicaid benefits pursuant to this chapter shall comply with  
 20 the provisions of **Sections 1 and 2 of this Act and** KRS 304.17A-163, 304.17A-  
 21 1631, 304.17A-167, 304.17A-235, 304.17A-257, 304.17A-259, 304.17A-515,  
 22 304.17A-580, 304.17A-600, 304.17A-603, 304.17A-607, and 304.17A-740 to  
 23 304.17A-743, as applicable.

24 (2) A managed care organization contracted to provide Medicaid benefits pursuant to  
 25 this chapter shall comply with the reporting requirements of KRS 304.17A-732.

26 ➔Section 4. KRS 205.6485 (Effective January 1, 2023) is amended to read as  
 27 follows:

- 1 (1) The Cabinet for Health and Family Services shall prepare a state child health plan  
2 meeting the requirements of Title XXI of the Federal Social Security Act, for  
3 submission to the Secretary of the United States Department of Health and Human  
4 Services within such time as will permit the state to receive the maximum amounts  
5 of federal matching funds available under Title XXI. The cabinet shall, by  
6 administrative regulation promulgated in accordance with KRS Chapter 13A,  
7 establish the following:
- 8 (a) The eligibility criteria for children covered by the Kentucky Children's Health  
9 Insurance Program. However, no person eligible for services under Title XIX  
10 of the Social Security Act, 42 U.S.C. secs. 1396 to 1396v, as amended, shall  
11 be eligible for services under the Kentucky Children's Health Insurance  
12 Program except to the extent that Title XIX coverage is expanded by KRS  
13 205.6481 to 205.6495 and KRS 304.17A-340;
- 14 (b) The schedule of benefits to be covered by the Kentucky Children's Health  
15 Insurance Program, which shall include preventive services, vision services  
16 including glasses, and dental services including at least sealants, extractions,  
17 and fillings, and which shall be at least equivalent to one (1) of the following:
- 18 1. The standard Blue Cross/Blue Shield preferred provider option under the  
19 Federal Employees Health Benefit Plan established by 5 U.S.C. sec.  
20 8903(1);
- 21 2. A mid-range health benefit coverage plan that is offered and generally  
22 available to state employees; or
- 23 3. Health insurance coverage offered by a health maintenance organization  
24 that has the largest insured commercial, non-Medicaid enrollment of  
25 covered lives in the state;
- 26 (c) The premium contribution per family of health insurance coverage available  
27 under the Kentucky Children's Health Insurance Program with provisions for

- 1 the payment of premium contributions by families of children eligible for  
2 coverage by the program based upon a sliding scale relating to family income.  
3 Premium contributions shall be based on a six (6) month period not to exceed:
- 4 1. Ten dollars (\$10), to be paid by a family with income between one  
5 hundred percent (100%) to one hundred thirty-three percent (133%) of  
6 the federal poverty level;
  - 7 2. Twenty dollars (\$20), to be paid by a family with income between one  
8 hundred thirty-four percent (134%) to one hundred forty-nine percent  
9 (149%) of the federal poverty level; and
  - 10 3. One hundred twenty dollars (\$120), to be paid by a family with income  
11 between one hundred fifty percent (150%) to two hundred percent  
12 (200%) of the federal poverty level, and which may be made on a partial  
13 payment plan of twenty dollars (\$20) per month or sixty dollars (\$60)  
14 per quarter;
- 15 (d) There shall be no copayments for services provided under the Kentucky  
16 Children's Health Insurance Program; and
- 17 (e) The criteria for health services providers and insurers wishing to contract with  
18 the Commonwealth to provide the children's health insurance coverage.  
19 However, the cabinet shall provide, in any contracting process for the  
20 preventive health insurance program, the opportunity for a public health  
21 department to bid on preventive health services to eligible children within the  
22 public health department's service area. A public health department shall not  
23 be disqualified from bidding because the department does not currently offer  
24 all the services required by paragraph (b) of this subsection. The criteria shall  
25 be set forth in administrative regulations under KRS Chapter 13A and shall  
26 maximize competition among the providers and insurers. The Cabinet for  
27 Finance and Administration shall provide oversight over contracting policies

1 and procedures to assure that the number of applicants for contracts is  
2 maximized.

3 (2) Within twelve (12) months of federal approval of the state's Title XXI child health  
4 plan, the Cabinet for Health and Family Services shall assure that a KCHIP program  
5 is available to all eligible children in all regions of the state. If necessary, in order to  
6 meet this assurance, the cabinet shall institute its own program.

7 (3) KCHIP recipients shall have direct access without a referral from any gatekeeper  
8 primary care provider to dentists for covered primary dental services and to  
9 optometrists and ophthalmologists for covered primary eye and vision services.

10 (4) The Kentucky Children's Health Insurance Program~~[Plan]~~ shall comply with:

11 (a) Sections 1 and 2 of this Act; and

12 (b) KRS 304.17A-163 and 304.17A-1631.

13 ➔Section 5. KRS 164.2871 (Effective January 1, 2023) is amended to read as  
14 follows:

15 (1) The governing board of each state postsecondary educational institution is  
16 authorized to purchase liability insurance for the protection of the individual  
17 members of the governing board, faculty, and staff of such institutions from liability  
18 for acts and omissions committed in the course and scope of the individual's  
19 employment or service. Each institution may purchase the type and amount of  
20 liability coverage deemed to best serve the interest of such institution.

21 (2) All retirement annuity allowances accrued or accruing to any employee of a state  
22 postsecondary educational institution through a retirement program sponsored by  
23 the state postsecondary educational institution are hereby exempt from any state,  
24 county, or municipal tax, and shall not be subject to execution, attachment,  
25 garnishment, or any other process whatsoever, nor shall any assignment thereof be  
26 enforceable in any court. Except retirement benefits accrued or accruing to any  
27 employee of a state postsecondary educational institution through a retirement

1 program sponsored by the state postsecondary educational institution on or after  
2 January 1, 1998, shall be subject to the tax imposed by KRS 141.020, to the extent  
3 provided in KRS 141.010 and 141.0215.

4 (3) Except as provided in KRS Chapter 44, the purchase of liability insurance for  
5 members of governing boards, faculty and staff of institutions of higher education in  
6 this state shall not be construed to be a waiver of sovereign immunity or any other  
7 immunity or privilege.

8 (4) The governing board of each state postsecondary education institution is authorized  
9 to provide a self-insured employer group health plan to its employees, which plan  
10 shall:

11 (a) Conform to the requirements of Subtitle 32 of KRS Chapter 304; and

12 (b) Except as provided in subsection (5) of this section, be exempt from  
13 conformity with Subtitle 17A of KRS Chapter 304.

14 (5) A self-insured employer group health plan provided by the governing board of a  
15 state postsecondary education institution to its employees shall comply with:

16 (a) Sections 1 and 2 of this Act; and

17 (b) KRS 304.17A-163 and 304.17A-1631.

18 ➔Section 6. KRS 18A.225 (Effective January 1, 2023) is amended to read as  
19 follows:

20 (1) (a) The term "employee" for purposes of this section means:

21 1. Any person, including an elected public official, who is regularly  
22 employed by any department, office, board, agency, or branch of state  
23 government; or by a public postsecondary educational institution; or by  
24 any city, urban-county, charter county, county, or consolidated local  
25 government, whose legislative body has opted to participate in the state-  
26 sponsored health insurance program pursuant to KRS 79.080; and who  
27 is either a contributing member to any one (1) of the retirement systems

- 1 administered by the state, including but not limited to the Kentucky  
2 Retirement Systems, County Employees Retirement System, Kentucky  
3 Teachers' Retirement System, the Legislators' Retirement Plan, or the  
4 Judicial Retirement Plan; or is receiving a contractual contribution from  
5 the state toward a retirement plan; or, in the case of a public  
6 postsecondary education institution, is an individual participating in an  
7 optional retirement plan authorized by KRS 161.567; or is eligible to  
8 participate in a retirement plan established by an employer who ceases  
9 participating in the Kentucky Employees Retirement System pursuant to  
10 KRS 61.522 whose employees participated in the health insurance plans  
11 administered by the Personnel Cabinet prior to the employer's effective  
12 cessation date in the Kentucky Employees Retirement System;
- 13 2. Any certified or classified employee of a local board of education or a  
14 public charter school as defined in KRS 160.1590;
- 15 3. Any elected member of a local board of education;
- 16 4. Any person who is a present or future recipient of a retirement  
17 allowance from the Kentucky Retirement Systems, County Employees  
18 Retirement System, Kentucky Teachers' Retirement System, the  
19 Legislators' Retirement Plan, the Judicial Retirement Plan, or the  
20 Kentucky Community and Technical College System's optional  
21 retirement plan authorized by KRS 161.567, except that a person who is  
22 receiving a retirement allowance and who is age sixty-five (65) or older  
23 shall not be included, with the exception of persons covered under KRS  
24 61.702(2)(b)3. and 78.5536(2)(b)3., unless he or she is actively  
25 employed pursuant to subparagraph 1. of this paragraph; and
- 26 5. Any eligible dependents and beneficiaries of participating employees  
27 and retirees who are entitled to participate in the state-sponsored health



1 insurance program;

2 (b) The term "health benefit plan" for the purposes of this section means a health  
3 benefit plan as defined in KRS 304.17A-005;

4 (c) The term "insurer" for the purposes of this section means an insurer as defined  
5 in KRS 304.17A-005; and

6 (d) The term "managed care plan" for the purposes of this section means a  
7 managed care plan as defined in KRS 304.17A-500.

8 (2) (a) The secretary of the Finance and Administration Cabinet, upon the  
9 recommendation of the secretary of the Personnel Cabinet, shall procure, in  
10 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,  
11 from one (1) or more insurers authorized to do business in this state, a group  
12 health benefit plan that may include but not be limited to health maintenance  
13 organization (HMO), preferred provider organization (PPO), point of service  
14 (POS), and exclusive provider organization (EPO) benefit plans encompassing  
15 all or any class or classes of employees. With the exception of employers  
16 governed by the provisions of KRS Chapters 16, 18A, and 151B, all  
17 employers of any class of employees or former employees shall enter into a  
18 contract with the Personnel Cabinet prior to including that group in the state  
19 health insurance group. The contracts shall include but not be limited to  
20 designating the entity responsible for filing any federal forms, adoption of  
21 policies required for proper plan administration, acceptance of the contractual  
22 provisions with health insurance carriers or third-party administrators, and  
23 adoption of the payment and reimbursement methods necessary for efficient  
24 administration of the health insurance program. Health insurance coverage  
25 provided to state employees under this section shall, at a minimum, contain  
26 the same benefits as provided under Kentucky Kare Standard as of January 1,  
27 1994, and shall include a mail-order drug option as provided in subsection

1 (13) of this section. All employees and other persons for whom the health care  
2 coverage is provided or made available shall annually be given an option to  
3 elect health care coverage through a self-funded plan offered by the  
4 Commonwealth or, if a self-funded plan is not available, from a list of  
5 coverage options determined by the competitive bid process under the  
6 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available  
7 during annual open enrollment.

8 (b) The policy or policies shall be approved by the commissioner of insurance and  
9 may contain the provisions the commissioner of insurance approves, whether  
10 or not otherwise permitted by the insurance laws.

11 (c) Any carrier bidding to offer health care coverage to employees shall agree to  
12 provide coverage to all members of the state group, including active  
13 employees and retirees and their eligible covered dependents and  
14 beneficiaries, within the county or counties specified in its bid. Except as  
15 provided in subsection ~~(19)~~~~(20)~~ of this section, any carrier bidding to offer  
16 health care coverage to employees shall also agree to rate all employees as a  
17 single entity, except for those retirees whose former employers insure their  
18 active employees outside the state-sponsored health insurance program and as  
19 otherwise provided in KRS 61.702(2)(b)3.b. and 78.5536(2)(b)3.b.

20 (d) Any carrier bidding to offer health care coverage to employees shall agree to  
21 provide enrollment, claims, and utilization data to the Commonwealth in a  
22 format specified by the Personnel Cabinet with the understanding that the data  
23 shall be owned by the Commonwealth; to provide data in an electronic form  
24 and within a time frame specified by the Personnel Cabinet; and to be subject  
25 to penalties for noncompliance with data reporting requirements as specified  
26 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions  
27 to protect the confidentiality of each individual employee; however,

1 confidentiality assertions shall not relieve a carrier from the requirement of  
2 providing stipulated data to the Commonwealth.

3 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities  
4 for timely analysis of data received from carriers and, to the extent possible,  
5 provide in the request-for-proposal specifics relating to data requirements,  
6 electronic reporting, and penalties for noncompliance. The Commonwealth  
7 shall own the enrollment, claims, and utilization data provided by each carrier  
8 and shall develop methods to protect the confidentiality of the individual. The  
9 Personnel Cabinet shall include in the October annual report submitted  
10 pursuant to the provisions of KRS 18A.226 to the Governor, the General  
11 Assembly, and the Chief Justice of the Supreme Court, an analysis of the  
12 financial stability of the program, which shall include but not be limited to  
13 loss ratios, methods of risk adjustment, measurements of carrier quality of  
14 service, prescription coverage and cost management, and statutorily required  
15 mandates. If state self-insurance was available as a carrier option, the report  
16 also shall provide a detailed financial analysis of the self-insurance fund  
17 including but not limited to loss ratios, reserves, and reinsurance agreements.

18 (f) If any agency participating in the state-sponsored employee health insurance  
19 program for its active employees terminates participation and there is a state  
20 appropriation for the employer's contribution for active employees' health  
21 insurance coverage, then neither the agency nor the employees shall receive  
22 the state-funded contribution after termination from the state-sponsored  
23 employee health insurance program.

24 (g) Any funds in flexible spending accounts that remain after all reimbursements  
25 have been processed shall be transferred to the credit of the state-sponsored  
26 health insurance plan's appropriation account.

27 (h) Each entity participating in the state-sponsored health insurance program shall

1 provide an amount at least equal to the state contribution rate for the employer  
2 portion of the health insurance premium. For any participating entity that used  
3 the state payroll system, the employer contribution amount shall be equal to  
4 but not greater than the state contribution rate.

5 (3) The premiums may be paid by the policyholder:

6 (a) Wholly from funds contributed by the employee, by payroll deduction or  
7 otherwise;

8 (b) Wholly from funds contributed by any department, board, agency, public  
9 postsecondary education institution, or branch of state, city, urban-county,  
10 charter county, county, or consolidated local government; or

11 (c) Partly from each, except that any premium due for health care coverage or  
12 dental coverage, if any, in excess of the premium amount contributed by any  
13 department, board, agency, postsecondary education institution, or branch of  
14 state, city, urban-county, charter county, county, or consolidated local  
15 government for any other health care coverage shall be paid by the employee.

16 (4) If an employee moves his or her place of residence or employment out of the service  
17 area of an insurer offering a managed health care plan, under which he or she has  
18 elected coverage, into either the service area of another managed health care plan or  
19 into an area of the Commonwealth not within a managed health care plan service  
20 area, the employee shall be given an option, at the time of the move or transfer, to  
21 change his or her coverage to another health benefit plan.

22 (5) No payment of premium by any department, board, agency, public postsecondary  
23 educational institution, or branch of state, city, urban-county, charter county,  
24 county, or consolidated local government shall constitute compensation to an  
25 insured employee for the purposes of any statute fixing or limiting the  
26 compensation of such an employee. Any premium or other expense incurred by any  
27 department, board, agency, public postsecondary educational institution, or branch

1 of state, city, urban-county, charter county, county, or consolidated local  
2 government shall be considered a proper cost of administration.

3 (6) The policy or policies may contain the provisions with respect to the class or classes  
4 of employees covered, amounts of insurance or coverage for designated classes or  
5 groups of employees, policy options, terms of eligibility, and continuation of  
6 insurance or coverage after retirement.

7 (7) Group rates under this section shall be made available to the disabled child of an  
8 employee regardless of the child's age if the entire premium for the disabled child's  
9 coverage is paid by the state employee. A child shall be considered disabled if he or  
10 she has been determined to be eligible for federal Social Security disability benefits.

11 (8) The health care contract or contracts for employees shall be entered into for a period  
12 of not less than one (1) year.

13 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of  
14 State Health Insurance Subscribers to advise the secretary or the secretary's designee  
15 regarding the state-sponsored health insurance program for employees. The  
16 secretary shall appoint, from a list of names submitted by appointing authorities,  
17 members representing school districts from each of the seven (7) Supreme Court  
18 districts, members representing state government from each of the seven (7)  
19 Supreme Court districts, two (2) members representing retirees under age sixty-five  
20 (65), one (1) member representing local health departments, two (2) members  
21 representing the Kentucky Teachers' Retirement System, and three (3) members at  
22 large. The secretary shall also appoint two (2) members from a list of five (5) names  
23 submitted by the Kentucky Education Association, two (2) members from a list of  
24 five (5) names submitted by the largest state employee organization of nonschool  
25 state employees, two (2) members from a list of five (5) names submitted by the  
26 Kentucky Association of Counties, two (2) members from a list of five (5) names  
27 submitted by the Kentucky League of Cities, and two (2) members from a list of

1 names consisting of five (5) names submitted by each state employee organization  
2 that has two thousand (2,000) or more members on state payroll deduction. The  
3 advisory committee shall be appointed in January of each year and shall meet  
4 quarterly.

5 (10) Notwithstanding any other provision of law to the contrary, the policy or policies  
6 provided to employees pursuant to this section shall not provide coverage for  
7 obtaining or performing an abortion, nor shall any state funds be used for the  
8 purpose of obtaining or performing an abortion on behalf of employees or their  
9 dependents.

10 (11) Interruption of an established treatment regime with maintenance drugs shall be  
11 grounds for an insured to appeal a formulary change through the established appeal  
12 procedures approved by the Department of Insurance, if the physician supervising  
13 the treatment certifies that the change is not in the best interests of the patient.

14 (12) Any employee who is eligible for and elects to participate in the state health  
15 insurance program as a retiree, or the spouse or beneficiary of a retiree, under any  
16 one (1) of the state-sponsored retirement systems shall not be eligible to receive the  
17 state health insurance contribution toward health care coverage as a result of any  
18 other employment for which there is a public employer contribution. This does not  
19 preclude a retiree and an active employee spouse from using both contributions to  
20 the extent needed for purchase of one (1) state sponsored health insurance policy for  
21 that plan year.

22 (13) (a) The policies of health insurance coverage procured under subsection (2) of  
23 this section shall include a mail-order drug option for maintenance drugs for  
24 state employees. Maintenance drugs may be dispensed by mail order in  
25 accordance with Kentucky law.

26 (b) A health insurer shall not discriminate against any retail pharmacy located  
27 within the geographic coverage area of the health benefit plan and that meets

1 the terms and conditions for participation established by the insurer, including  
2 price, dispensing fee, and copay requirements of a mail-order option. The  
3 retail pharmacy shall not be required to dispense by mail.

4 (c) The mail-order option shall not permit the dispensing of a controlled  
5 substance classified in Schedule II.

6 (14) The policy or policies provided to state employees or their dependents pursuant to  
7 this section shall provide coverage for obtaining a hearing aid and acquiring hearing  
8 aid-related services for insured individuals under eighteen (18) years of age, subject  
9 to a cap of one thousand four hundred dollars (\$1,400) every thirty-six (36) months  
10 pursuant to KRS 304.17A-132.

11 (15) Any policy provided to state employees or their dependents pursuant to this section  
12 shall provide coverage for the diagnosis and treatment of autism spectrum disorders  
13 consistent with KRS 304.17A-142.

14 ~~(16) Any policy provided to state employees or their dependents pursuant to this section~~  
15 ~~shall provide coverage for obtaining amino acid based elemental formula pursuant~~  
16 ~~to KRS 304.17A-258.~~

17 ~~(17)~~ If a state employee's residence and place of employment are in the same county, and  
18 if the hospital located within that county does not offer surgical services, intensive  
19 care services, obstetrical services, level II neonatal services, diagnostic cardiac  
20 catheterization services, and magnetic resonance imaging services, the employee  
21 may select a plan available in a contiguous county that does provide those services,  
22 and the state contribution for the plan shall be the amount available in the county  
23 where the plan selected is located.

24 (17)~~(18)~~ If a state employee's residence and place of employment are each located in  
25 counties in which the hospitals do not offer surgical services, intensive care  
26 services, obstetrical services, level II neonatal services, diagnostic cardiac  
27 catheterization services, and magnetic resonance imaging services, the employee

1           may select a plan available in a county contiguous to the county of residence that  
2           does provide those services, and the state contribution for the plan shall be the  
3           amount available in the county where the plan selected is located.

4           ~~(18)~~~~(19)~~ The Personnel Cabinet is encouraged to study whether it is fair and reasonable  
5           and in the best interests of the state group to allow any carrier bidding to offer  
6           health care coverage under this section to submit bids that may vary county by  
7           county or by larger geographic areas.

8           ~~(19)~~~~(20)~~ Notwithstanding any other provision of this section, the bid for proposals for  
9           health insurance coverage for calendar year 2004 shall include a bid scenario that  
10          reflects the statewide rating structure provided in calendar year 2003 and a bid  
11          scenario that allows for a regional rating structure that allows carriers to submit bids  
12          that may vary by region for a given product offering as described in this subsection:

13          (a) The regional rating bid scenario shall not include a request for bid on a  
14          statewide option;

15          (b) The Personnel Cabinet shall divide the state into geographical regions which  
16          shall be the same as the partnership regions designated by the Department for  
17          Medicaid Services for purposes of the Kentucky Health Care Partnership  
18          Program established pursuant to 907 KAR 1:705;

19          (c) The request for proposal shall require a carrier's bid to include every county  
20          within the region or regions for which the bid is submitted and include but not  
21          be restricted to a preferred provider organization (PPO) option;

22          (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the  
23          carrier all of the counties included in its bid within the region. If the Personnel  
24          Cabinet deems the bids submitted in accordance with this subsection to be in  
25          the best interests of state employees in a region, the cabinet may award the  
26          contract for that region to no more than two (2) carriers; and

27          (e) Nothing in this subsection shall prohibit the Personnel Cabinet from including



1 other requirements or criteria in the request for proposal.

2 ~~(20)~~~~(21)~~ Any fully insured health benefit plan or self-insured plan issued or renewed on  
 3 or after July 12, 2006, to public employees pursuant to this section which provides  
 4 coverage for services rendered by a physician or osteopath duly licensed under KRS  
 5 Chapter 311 that are within the scope of practice of an optometrist duly licensed  
 6 under the provisions of KRS Chapter 320 shall provide the same payment of  
 7 coverage to optometrists as allowed for those services rendered by physicians or  
 8 osteopaths.

9 ~~(21)~~~~(22)~~ Any fully insured health benefit plan or self-insured plan issued or renewed to  
 10 public employees pursuant to this section shall comply with:

- 11 (a) KRS 304.12-237;
- 12 (b) KRS 304.17A-270 and 304.17A-525;
- 13 (c) KRS 304.17A-600 to 304.17A-633;
- 14 (d) KRS 205.593;
- 15 (e) KRS 304.17A-700 to 304.17A-730;
- 16 (f) KRS 304.14-135;
- 17 (g) KRS 304.17A-580 and 304.17A-641;
- 18 (h) KRS 304.99-123;
- 19 (i) KRS 304.17A-138;
- 20 (j) KRS 304.17A-148;
- 21 (k) KRS 304.17A-163 and 304.17A-1631;~~and~~
- 22 (l) **Sections 1 and 2 of this Act; and**
- 23 **(m)** Administrative regulations promulgated pursuant to statutes listed in this  
 24 subsection.

25 ➔Section 7. KRS 205.560 is amended to read as follows:

- 26 (1) The scope of medical care for which the Cabinet for Health and Family Services  
 27 undertakes to pay shall be designated and limited by regulations promulgated by the

1 cabinet, pursuant to the provisions in this section. Within the limitations of any  
2 appropriation therefor, the provision of complete upper and lower dentures to  
3 recipients of Medical Assistance Program benefits who have their teeth removed by  
4 a dentist resulting in the total absence of teeth shall be a mandatory class in the  
5 scope of medical care. Payment to a dentist of any Medical Assistance Program  
6 benefits for complete upper and lower dentures shall only be provided on the  
7 condition of a preauthorized agreement between an authorized representative of the  
8 Medical Assistance Program and the dentist prior to the removal of the teeth. The  
9 selection of another class or other classes of medical care shall be recommended by  
10 the council to the secretary for health and family services after taking into  
11 consideration, among other things, the amount of federal and state funds available,  
12 the most essential needs of recipients, and the meeting of such need on a basis  
13 insuring the greatest amount of medical care as defined in KRS 205.510 consonant  
14 with the funds available, including but not limited to the following categories,  
15 except where the aid is for the purpose of obtaining an abortion:

- 16 (a) Hospital care, including drugs, and medical supplies and services during any  
17 period of actual hospitalization;
- 18 (b) Nursing-home care, including medical supplies and services, and drugs during  
19 confinement therein on prescription of a physician, dentist, or podiatrist;
- 20 (c) Drugs, nursing care, medical supplies, and services during the time when a  
21 recipient is not in a hospital but is under treatment and on the prescription of a  
22 physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall  
23 include those products covered under Section 1 of this Act~~for the treatment~~  
24 ~~of inborn errors of metabolism or genetic, gastrointestinal, and food allergic~~  
25 ~~conditions, consisting of therapeutic food, formulas, supplements, amino acid-~~  
26 ~~based elemental formula, or low protein modified food products that are~~  
27 ~~medically indicated for therapeutic treatment and are administered under the~~

- 1           ~~direction of a physician,~~ and include but ~~are~~ not ***be*** limited to ***products for***  
2           the following conditions:
- 3           1.    Phenylketonuria;
  - 4           2.    Hyperphenylalaninemia;
  - 5           3.    Tyrosinemia (types I, II, and III);
  - 6           4.    Maple syrup urine disease;
  - 7           5.    A-ketoacid dehydrogenase deficiency;
  - 8           6.    Isovaleryl-CoA dehydrogenase deficiency;
  - 9           7.    3-methylcrotonyl-CoA carboxylase deficiency;
  - 10          8.    3-methylglutaconyl-CoA hydratase deficiency;
  - 11          9.    3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase  
12            deficiency);
  - 13          10.   B-ketothiolase deficiency;
  - 14          11.   Homocystinuria;
  - 15          12.   Glutaric aciduria (types I and II);
  - 16          13.   Lysinuric protein intolerance;
  - 17          14.   Non-ketotic hyperglycinemia;
  - 18          15.   Propionic acidemia;
  - 19          16.   Gyrate atrophy;
  - 20          17.   Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
  - 21          18.   Carbamoyl phosphate synthetase deficiency;
  - 22          19.   Ornithine carbamoyl transferase deficiency;
  - 23          20.   Citrullinemia;
  - 24          21.   Arginosuccinic aciduria;
  - 25          22.   Methylmalonic acidemia;
  - 26          23.   Argininemia;
  - 27          24.   Food protein allergies;

- 1           25. Food protein-induced enterocolitis syndrome;
- 2           26. Eosinophilic disorders; and
- 3           27. Short bowel syndrome;
- 4       (d) Physician, podiatric, and dental services;
- 5       (e) Optometric services for all age groups shall be limited to prescription services,
- 6           services to frames and lenses, and diagnostic services provided by an
- 7           optometrist, to the extent the optometrist is licensed to perform the services
- 8           and to the extent the services are covered in the ophthalmologist portion of the
- 9           physician's program. Eyeglasses shall be provided only to children under age
- 10          twenty-one (21);
- 11       (f) Drugs on the prescription of a physician used to prevent the rejection of
- 12          transplanted organs if the patient is indigent; and
- 13       (g) Nonprofit neighborhood health organizations or clinics where some or all of
- 14          the medical services are provided by licensed registered nurses or by advanced
- 15          medical students presently enrolled in a medical school accredited by the
- 16          Association of American Medical Colleges and where the students or licensed
- 17          registered nurses are under the direct supervision of a licensed physician who
- 18          rotates his services in this supervisory capacity between two (2) or more of the
- 19          nonprofit neighborhood health organizations or clinics specified in this
- 20          paragraph.
- 21   (2) Payments for hospital care, nursing-home care, and drugs or other medical,
- 22          ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount
- 23          of the payment to the cost of providing the services or supplies. It shall be one (1) of
- 24          the functions of the council to make recommendations to the Cabinet for Health and
- 25          Family Services with respect to the bases for payment. In determining the rates of
- 26          reimbursement for long-term-care facilities participating in the Medical Assistance
- 27          Program, the Cabinet for Health and Family Services shall, to the extent permitted

1 by federal law, not allow the following items to be considered as a cost to the  
2 facility for purposes of reimbursement:

- 3 (a) Motor vehicles that are not owned by the facility, including motor vehicles  
4 that are registered or owned by the facility but used primarily by the owner or  
5 family members thereof;
- 6 (b) The cost of motor vehicles, including vans or trucks, used for facility business  
7 shall be allowed up to fifteen thousand dollars (\$15,000) per facility, adjusted  
8 annually for inflation according to the increase in the consumer price index-u  
9 for the most recent twelve (12) month period, as determined by the United  
10 States Department of Labor. Medically equipped motor vehicles, vans, or  
11 trucks shall be exempt from the fifteen thousand dollar (\$15,000) limitation.  
12 Costs exceeding this limit shall not be reimbursable and shall be borne by the  
13 facility. Costs for additional motor vehicles, not to exceed a total of three (3)  
14 per facility, may be approved by the Cabinet for Health and Family Services if  
15 the facility demonstrates that each additional vehicle is necessary for the  
16 operation of the facility as required by regulations of the cabinet;
- 17 (c) Salaries paid to immediate family members of the owner or administrator, or  
18 both, of a facility, to the extent that services are not actually performed and are  
19 not a necessary function as required by regulation of the cabinet for the  
20 operation of the facility. The facility shall keep a record of all work actually  
21 performed by family members;
- 22 (d) The cost of contracts, loans, or other payments made by the facility to owners,  
23 administrators, or both, unless the payments are for services which would  
24 otherwise be necessary to the operation of the facility and the services are  
25 required by regulations of the Cabinet for Health and Family Services. Any  
26 other payments shall be deemed part of the owner's compensation in  
27 accordance with maximum limits established by regulations of the Cabinet for

- 1 Health and Family Services. Interest paid to the facility for loans made to a  
2 third party may be used to offset allowable interest claimed by the facility;
- 3 (e) Private club memberships for owners or administrators, travel expenses for  
4 trips outside the state for owners or administrators, and other indirect  
5 payments made to the owner, unless the payments are deemed part of the  
6 owner's compensation in accordance with maximum limits established by  
7 regulations of the Cabinet for Health and Family Services; and
- 8 (f) Payments made to related organizations supplying the facility with goods or  
9 services shall be limited to the actual cost of the goods or services to the  
10 related organization, unless it can be demonstrated that no relationship  
11 between the facility and the supplier exists. A relationship shall be considered  
12 to exist when an individual, including brothers, sisters, father, mother, aunts,  
13 uncles, and in-laws, possesses a total of five percent (5%) or more of  
14 ownership equity in the facility and the supplying business. An exception to  
15 the relationship shall exist if fifty-one percent (51%) or more of the supplier's  
16 business activity of the type carried on with the facility is transacted with  
17 persons and organizations other than the facility and its related organizations.
- 18 (3) No vendor payment shall be made unless the class and type of medical care  
19 rendered and the cost basis therefor has first been designated by regulation.
- 20 (4) The rules and regulations of the Cabinet for Health and Family Services shall  
21 require that a written statement, including the required opinion of a physician, shall  
22 accompany any claim for reimbursement for induced premature births. This  
23 statement shall indicate the procedures used in providing the medical services.
- 24 (5) The range of medical care benefit standards provided and the quality and quantity  
25 standards and the methods for determining cost formulae for vendor payments  
26 within each category of public assistance and other recipients shall be uniform for  
27 the entire state, and shall be designated by regulation promulgated within the

1 limitations established by the Social Security Act and federal regulations. It shall  
2 not be necessary that the amount of payments for units of services be uniform for  
3 the entire state but amounts may vary from county to county and from city to city, as  
4 well as among hospitals, based on the prevailing cost of medical care in each locale  
5 and other local economic and geographic conditions, except that insofar as allowed  
6 by applicable federal law and regulation, the maximum amounts reimbursable for  
7 similar services rendered by physicians within the same specialty of medical  
8 practice shall not vary according to the physician's place of residence or place of  
9 practice, as long as the place of practice is within the boundaries of the state.

10 (6) Nothing in this section shall be deemed to deprive a woman of all appropriate  
11 medical care necessary to prevent her physical death.

12 (7) To the extent permitted by federal law, no medical assistance recipient shall be  
13 recertified as qualifying for a level of long-term care below the recipient's current  
14 level, unless the recertification includes a physical examination conducted by a  
15 physician licensed pursuant to KRS Chapter 311 or by an advanced practice  
16 registered nurse licensed pursuant to KRS Chapter 314 and acting under the  
17 physician's supervision.

18 (8) If payments made to community mental health centers, established pursuant to KRS  
19 Chapter 210, for services provided to the intellectually disabled exceed the actual  
20 cost of providing the service, the balance of the payments shall be used solely for  
21 the provision of other services to the intellectually disabled through community  
22 mental health centers.

23 (9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to  
24 recipients of medical assistance under Title XIX of the Social Security Act on July  
25 15, 1986, shall deny admission of a person to a bed certified for reimbursement  
26 under the provisions of the Medical Assistance Program solely on the basis of the  
27 person's paying status as a Medicaid recipient. No person shall be removed or

1 discharged from any facility solely because they became eligible for participation in  
2 the Medical Assistance Program, unless the facility can demonstrate the resident or  
3 the resident's responsible party was fully notified in writing that the resident was  
4 being admitted to a bed not certified for Medicaid reimbursement. No facility may  
5 decertify a bed occupied by a Medicaid recipient or may decertify a bed that is  
6 occupied by a resident who has made application for medical assistance.

7 (10) Family-practice physicians practicing in geographic areas with no more than one (1)  
8 primary-care physician per five thousand (5,000) population, as reported by the  
9 United States Department of Health and Human Services, shall be reimbursed one  
10 hundred twenty-five percent (125%) of the standard reimbursement rate for  
11 physician services.

12 (11) The Cabinet for Health and Family Services shall make payments under the Medical  
13 Assistance program for services which are within the lawful scope of practice of a  
14 chiropractor licensed pursuant to KRS Chapter 312, to the extent the Medical  
15 Assistance Program pays for the same services provided by a physician.

16 (12) (a) The Medical Assistance Program shall use the appropriate form and  
17 guidelines for enrolling those providers applying for participation in the  
18 Medical Assistance Program, including those licensed and regulated under  
19 KRS Chapters 311, 312, 314, 315, and 320, any facility required to be  
20 licensed pursuant to KRS Chapter 216B, and any other health care practitioner  
21 or facility as determined by the Department for Medicaid Services through an  
22 administrative regulation promulgated under KRS Chapter 13A. A Medicaid  
23 managed care organization shall use the forms and guidelines established  
24 under KRS 304.17A-545(5) to credential a provider. For any provider who  
25 contracts with and is credentialed by a Medicaid managed care organization  
26 prior to enrollment, the cabinet shall complete the enrollment process and  
27 deny, or approve and issue a Provider Identification Number (PID) within



1 fifteen (15) business days from the time all necessary completed enrollment  
2 forms have been submitted and all outstanding accounts receivable have been  
3 satisfied.

4 (b) Within forty-five (45) days of receiving a correct and complete provider  
5 application, the Department for Medicaid Services shall complete the  
6 enrollment process by either denying or approving and issuing a Provider  
7 Identification Number (PID) for a behavioral health provider who provides  
8 substance use disorder services, unless the department notifies the provider  
9 that additional time is needed to render a decision for resolution of an issue or  
10 dispute.

11 (c) Within forty-five (45) days of receipt of a correct and complete application for  
12 credentialing by a behavioral health provider providing substance use disorder  
13 services, a Medicaid managed care organization shall complete its contracting  
14 and credentialing process, unless the Medicaid managed care organization  
15 notifies the provider that additional time is needed to render a decision. If  
16 additional time is needed, the Medicaid managed care organization shall not  
17 take any longer than ninety (90) days from receipt of the credentialing  
18 application to deny or approve and contract with the provider.

19 (d) A Medicaid managed care organization shall adjudicate any clean claims  
20 submitted for a substance use disorder service from an enrolled and  
21 credentialed behavioral health provider who provides substance use disorder  
22 services in accordance with KRS 304.17A-700 to 304.17A-730.

23 (e) The Department of Insurance may impose a civil penalty of one hundred  
24 dollars (\$100) per violation when a Medicaid managed care organization fails  
25 to comply with this section. Each day that a Medicaid managed care  
26 organization fails to pay a claim may count as a separate violation.

27 (13) Dentists licensed under KRS Chapter 313 shall be excluded from the requirements

1 of subsection (12) of this section. The Department for Medicaid Services shall  
2 develop a specific form and establish guidelines for assessing the credentials of  
3 dentists applying for participation in the Medical Assistance Program.

4 ➔Section 8. Sections 1 and 2 of this Act apply to health benefit plans issued or  
5 renewed on or after January 1, 2024.

6 ➔Section 9. If the Cabinet for Health and Family Services determines that a  
7 waiver or any other authorization from a federal agency is necessary to implement  
8 Section 3, 4, 6, or 7 of this Act for any reason, including the loss of federal funds, the  
9 cabinet shall, within 90 days after the effective date of this section, request the waiver or  
10 authorization, and may only delay implementation of those provisions for which a waiver  
11 or authorization was deemed necessary until the waiver or authorization is granted.

12 ➔Section 10. Sections 1 to 8 of this Act take effect January 1, 2024.