

1 AN ACT relating to coverage for prosthetics and orthotics.

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

3 ➔SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304
4 IS CREATED TO READ AS FOLLOWS:

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

6 *(a) "Cost-sharing" means the cost to an individual insured under a health*
7 *benefit plan according to any coverage limit, copayment, coinsurance,*
8 *deductible, or other out-of-pocket expense requirements imposed by the*
9 *plan;*

10 *(b) "Coverage for prosthetic and orthotic devices" means coverage for:*

11 *1. The most appropriate prosthetic and orthotic devices that are*
12 *determined by a treating physician to be medically necessary to restore*
13 *a covered person's functionality to optimal levels;*

14 *2. Any services and supplies necessary for the effective use of prosthetic*
15 *and orthotic devices, including:*

16 *a. Formulation of the device's design;*

17 *b. Fabrication;*

18 *c. Material and component selection;*

19 *d. Measurements;*

20 *e. Fittings;*

21 *f. Static and dynamic alignments;*

22 *g. Instruction of the covered person in the use of the device; and*

23 *h. Any materials and components necessary to use the device;*

24 *3. Any repair or replacement of prosthetic and orthotic devices that is*
25 *medically necessary to restore or maintain a covered person's ability to*
26 *complete activities of daily living or essential job-related activities; and*

27 *4. Any other benefit for or relating to prosthetic and orthotic devices that*

1 is currently covered by Medicare;

2 (c) "Orthotic device" means a custom-made, rigid or semi-rigid device
 3 designed to:

4 1. Support, align, prevent, or correct a defect or deformity in, or improve
 5 the function of, a movable part of the body; or

6 2. Restrict or eliminate motion in a weak, diseased, or injured body part;

7 and

8 (d) "Prosthetic device" means an external artificial device or appliance
 9 designed to replace all or part of:

10 1. One (1) or both arms;

11 2. One (1) or both legs;

12 3. A foot;

13 4. A hand;

14 5. A face;

15 6. An eye;

16 7. An ear;

17 8. A nose; or

18 9. One (1) or both breasts, if required by federal law.

19 (2) All health benefit plans issued or renewed on or after the effective date of this Act
 20 shall provide coverage for prosthetic and orthotic devices, except coverage shall
 21 not be required for the repair or replacement of devices:

22 (a) Due to misuse, malicious damage, or gross neglect; or

23 (b) That are lost or stolen.

24 (3) Coverage required by this section:

25 (a) May be subject to the same cost-sharing that applies to other medical
 26 devices and services covered by the health benefit plan; and

27 (b) Shall include reimbursement for devices and services that is no less

1 *favorable than the reimbursement provided by the health benefit plan for*
 2 *other medical devices and services, including restorative internal devices*
 3 *and services, such as internal prosthetic devices. At a minimum,*
 4 *reimbursement for a covered device or service shall be equal to the*
 5 *reimbursement provided by Medicare's current fee schedule for the same or*
 6 *substantially similar device or service.*

7 *(4) This section shall not be construed as requiring a health benefit plan to provide*
 8 *coverage for the repair or replacement of a prosthetic or orthotic device for the*
 9 *sole purpose of providing comfort or convenience to a covered person.*

10 ➔Section 2. KRS 304.17A-515 is amended to read as follows:

11 (1) A managed care plan shall arrange for a sufficient number and type of primary care
 12 providers and specialists throughout the plan's service area to meet the needs of
 13 enrollees. Each managed care plan shall demonstrate that it offers:

14 (a) An adequate number of accessible acute care hospital services, where
 15 physically available;

16 (b) An adequate number of accessible primary care providers, including family
 17 practice and general practice physicians, internists,
 18 obstetricians/gynecologists, and pediatricians, where available;

19 (c) An adequate number of accessible specialists and subspecialists, and when the
 20 specialist needed for a specific condition is not represented on the plan's list of
 21 participating specialists, enrollees have access to nonparticipating health care
 22 providers with prior plan approval;

23 (d) The availability of specialty services;

24 *(e) The availability of:*

25 *1. Health care providers that practice in the area of prosthetics and*
 26 *orthotics; and*

27 *2. At least two (2) distinct professionals that provide devices and services*

1 covered under Section 1 of this Act; and

2 ~~(f)(e)~~ A provider network that meets the following accessibility requirements:

3 1. For urban areas, a provider network that is available to all persons
4 enrolled in the plan within thirty (30) miles or thirty (30) minutes of
5 each person's place of residence or work, to the extent that services are
6 available; or

7 2. For areas other than urban areas, a provider network that makes
8 available primary care physician services, hospital services, and
9 pharmacy services within thirty (30) minutes or thirty (30) miles of each
10 enrollee's place of residence or work, to the extent those services are
11 available. All other providers shall be available to all persons enrolled in
12 the plan within fifty (50) minutes or fifty (50) miles of each enrollee's
13 place of residence or work, to the extent those services are available.

14 (2) A managed care plan shall provide telephone access to the plan during business
15 hours to ensure plan approval of nonemergency care. A managed care plan shall
16 provide adequate information to enrollees regarding access to urgent and emergency
17 care.

18 (3) A managed care plan shall establish reasonable standards for waiting times to obtain
19 appointments, except as provided for emergency care.

20 ➔Section 3. KRS 304.17A-254 is amended to read as follows:

21 An insurer that offers a health benefit plan that is not a managed care plan as defined in
22 KRS 304.17A-500, but provides financial incentives for a covered person to access a
23 network of providers shall:

24 (1) Notify the covered person, in writing, of the availability of a printed document, in a
25 manner consistent with KRS 304.14-420 to 304.14-450, containing the following
26 information at the time of enrollment and upon request:

27 (a) A current directory of the in-network providers from which the covered

1 person may access covered services at a financially beneficial rate. The
 2 directory shall, at a minimum, provide the name, type of provider,
 3 professional office address, telephone number, and specialty designations of
 4 the network provider, if any; and

5 (b) In addition to making the information available in a printed document, an
 6 insurer may also make the information available in an accessible electronic
 7 format;

8 (2) **Ensure**~~[Assure]~~ that contracts with the providers in the network contain a hold
 9 harmless agreement under which the covered person will not be balanced billed by
 10 the in-network provider except for deductibles, co-pays, coinsurance amounts, and
 11 noncovered benefits;

12 (3) File with the department a copy of the directory required under subsection (1) of
 13 this section;

14 (4) **(a)** Have a process for the selection of health care providers who will be on the
 15 insurer's list of participating providers, with written policies and procedures
 16 for review and approval used by the insurer~~[-];~~;

17 **(b)** ~~[The insurer shall]~~Establish minimum professional requirements for
 18 participating health care providers~~[-];~~;

19 **(c)** ~~[An insurer may]~~Not discriminate against a provider solely on the basis of the
 20 provider's license by the state; **and**

21 **(d) Demonstrate that the insurer's list of participating providers offers the**
 22 **availability of:**

23 **1. Health care providers that practice in the area of prosthetics and**
 24 **orthotics; and**

25 **2. At least two (2) distinct professionals that provide devices and services**
 26 **covered under Section 1 of this Act;**

27 (5) Not contract with a health care provider to limit the provider's disclosure to a

- 1 covered person, or to another person on behalf of a covered person, of any
2 information relating to the covered person's medical condition or treatment options;
- 3 (6) Not penalize a health care provider, or terminate a health care provider's contract
4 with the insurer, because the provider discusses medically necessary or appropriate
5 care with a covered person or another person on behalf of a covered person. The
6 health care provider may:
- 7 (a) Not be prohibited by the insurer from discussing all treatment options with the
8 covered person; and
- 9 (b) Disclose to the covered person or to another person on behalf of a covered
10 person other information determined by the health care provider to be in the
11 best interests of the covered person;
- 12 (7) Include in any agreements it enters into with providers for the provision of health
13 care services a clause stating that the insurer shall~~will~~, upon request of a health
14 care provider, provide or make available to a health care provider, when contracting
15 or renewing an existing contract with the~~such~~ provider, the payment or fee
16 schedules or other information sufficient to enable the health care provider to
17 determine the manner and amount of payments under the contract for the health care
18 provider's services prior to the final execution or renewal of the contract and shall
19 provide any change in these~~such~~ schedules at least ninety (90) days prior to the
20 effective date of the amendment pursuant to KRS 304.17A-577;
- 21 (8) Establish a policy governing the removal of and withdrawal by health care providers
22 from the provider network that includes the following:
- 23 (a) The insurer shall inform a participating health care provider of the insurer's
24 removal and withdrawal policy at the time the insurer contracts with the health
25 care provider to participate in the provider network, and when changed
26 thereafter;
- 27 (b) If a participating health care provider's participation will be terminated or

1 withdrawn prior to the date of the termination of the contract as a result of a
2 professional review action, the insurer and participating health care provider
3 shall comply with the standards in 42 U.S.C. sec. 11112; and

4 (c) If the insurer finds that a health care provider represents an imminent danger
5 to an individual patient or to the public health, safety, or welfare, the medical
6 director shall promptly notify the appropriate professional state licensing
7 board; and

8 (9) Meet all requirements provided under KRS 304.17A-600 to 304.17A-633 and KRS
9 304.17A-700 to 304.17A-730.

10 ➔Section 4. KRS 18A.225 is amended to read as follows:

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

12 1. Any person, including an elected public official, who is regularly
13 employed by any department, office, board, agency, or branch of state
14 government; or by a public postsecondary educational institution; or by
15 any city, urban-county, charter county, county, or consolidated local
16 government, whose legislative body has opted to participate in the state-
17 sponsored health insurance program pursuant to KRS 79.080; and who
18 is either a contributing member to any one (1) of the retirement systems
19 administered by the state, including but not limited to the Kentucky
20 Retirement Systems, Kentucky Teachers' Retirement System, the
21 Legislators' Retirement Plan, or the Judicial Retirement Plan; or is
22 receiving a contractual contribution from the state toward a retirement
23 plan; or, in the case of a public postsecondary education institution, is an
24 individual participating in an optional retirement plan authorized by
25 KRS 161.567; or is eligible to participate in a retirement plan
26 established by an employer who ceases participating in the Kentucky
27 Employees Retirement System pursuant to KRS 61.522 whose

- 1 employees participated in the health insurance plans administered by the
2 Personnel Cabinet prior to the employer's effective cessation date in the
3 Kentucky Employees Retirement System;
- 4 2. Any certified or classified employee of a local board of education;
- 5 3. Any elected member of a local board of education;
- 6 4. Any person who is a present or future recipient of a retirement
7 allowance from the Kentucky Retirement Systems, Kentucky Teachers'
8 Retirement System, the Legislators' Retirement Plan, the Judicial
9 Retirement Plan, or the Kentucky Community and Technical College
10 System's optional retirement plan authorized by KRS 161.567, except
11 that a person who is receiving a retirement allowance and who is age
12 sixty-five (65) or older shall not be included, with the exception of
13 persons covered under KRS 61.702(4)(c), unless he or she is actively
14 employed pursuant to subparagraph 1. of this paragraph; and
- 15 5. Any eligible dependents and beneficiaries of participating employees
16 and retirees who are entitled to participate in the state-sponsored health
17 insurance program;
- 18 (b) The term "health benefit plan" for the purposes of this section means a health
19 benefit plan as defined in KRS 304.17A-005;
- 20 (c) The term "insurer" for the purposes of this section means an insurer as defined
21 in KRS 304.17A-005; and
- 22 (d) The term "managed care plan" for the purposes of this section means a
23 managed care plan as defined in KRS 304.17A-500.
- 24 (2) (a) The secretary of the Finance and Administration Cabinet, upon the
25 recommendation of the secretary of the Personnel Cabinet, shall procure, in
26 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,
27 from one (1) or more insurers authorized to do business in this state, a group

1 health benefit plan that may include but not be limited to health maintenance
2 organization (HMO), preferred provider organization (PPO), point of service
3 (POS), and exclusive provider organization (EPO) benefit plans encompassing
4 all or any class or classes of employees. With the exception of employers
5 governed by the provisions of KRS Chapters 16, 18A, and 151B, all
6 employers of any class of employees or former employees shall enter into a
7 contract with the Personnel Cabinet prior to including that group in the state
8 health insurance group. The contracts shall include but not be limited to
9 designating the entity responsible for filing any federal forms, adoption of
10 policies required for proper plan administration, acceptance of the contractual
11 provisions with health insurance carriers or third-party administrators, and
12 adoption of the payment and reimbursement methods necessary for efficient
13 administration of the health insurance program. Health insurance coverage
14 provided to state employees under this section shall, at a minimum, contain
15 the same benefits as provided under Kentucky Kare Standard as of January 1,
16 1994, and shall include a mail-order drug option as provided in subsection
17 (13) of this section. All employees and other persons for whom the health care
18 coverage is provided or made available shall annually be given an option to
19 elect health care coverage through a self-funded plan offered by the
20 Commonwealth or, if a self-funded plan is not available, from a list of
21 coverage options determined by the competitive bid process under the
22 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available
23 during annual open enrollment.

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

27 (c) Any carrier bidding to offer health care coverage to employees shall agree to

1 provide coverage to all members of the state group, including active
2 employees and retirees and their eligible covered dependents and
3 beneficiaries, within the county or counties specified in its bid. Except as
4 provided in subsection (20) of this section, any carrier bidding to offer health
5 care coverage to employees shall also agree to rate all employees as a single
6 entity, except for those retirees whose former employers insure their active
7 employees outside the state-sponsored health insurance program.

8 (d) Any carrier bidding to offer health care coverage to employees shall agree to
9 provide enrollment, claims, and utilization data to the Commonwealth in a
10 format specified by the Personnel Cabinet with the understanding that the data
11 shall be owned by the Commonwealth; to provide data in an electronic form
12 and within a time frame specified by the Personnel Cabinet; and to be subject
13 to penalties for noncompliance with data reporting requirements as specified
14 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions
15 to protect the confidentiality of each individual employee; however,
16 confidentiality assertions shall not relieve a carrier from the requirement of
17 providing stipulated data to the Commonwealth.

18 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities
19 for timely analysis of data received from carriers and, to the extent possible,
20 provide in the request-for-proposal specifics relating to data requirements,
21 electronic reporting, and penalties for noncompliance. The Commonwealth
22 shall own the enrollment, claims, and utilization data provided by each carrier
23 and shall develop methods to protect the confidentiality of the individual. The
24 Personnel Cabinet shall include in the October annual report submitted
25 pursuant to the provisions of KRS 18A.226 to the Governor, the General
26 Assembly, and the Chief Justice of the Supreme Court, an analysis of the
27 financial stability of the program, which shall include but not be limited to

1 loss ratios, methods of risk adjustment, measurements of carrier quality of
2 service, prescription coverage and cost management, and statutorily required
3 mandates. If state self-insurance was available as a carrier option, the report
4 also shall provide a detailed financial analysis of the self-insurance fund
5 including but not limited to loss ratios, reserves, and reinsurance agreements.

6 (f) If any agency participating in the state-sponsored employee health insurance
7 program for its active employees terminates participation and there is a state
8 appropriation for the employer's contribution for active employees' health
9 insurance coverage, then neither the agency nor the employees shall receive
10 the state-funded contribution after termination from the state-sponsored
11 employee health insurance program.

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

15 (h) Each entity participating in the state-sponsored health insurance program shall
16 provide an amount at least equal to the state contribution rate for the employer
17 portion of the health insurance premium. For any participating entity that used
18 the state payroll system, the employer contribution amount shall be equal to
19 but not greater than the state contribution rate.

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

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

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

26 (c) Partly from each, except that any premium due for health care coverage or
27 dental coverage, if any, in excess of the premium amount contributed by any

1 department, board, agency, postsecondary education institution, or branch of
2 state, city, urban-county, charter county, county, or consolidated local
3 government for any other health care coverage shall be paid by the employee.

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

10 (5) No payment of premium by any department, board, agency, public postsecondary
11 educational institution, or branch of state, city, urban-county, charter county,
12 county, or consolidated local government shall constitute compensation to an
13 insured employee for the purposes of any statute fixing or limiting the
14 compensation of such an employee. Any premium or other expense incurred by any
15 department, board, agency, public postsecondary educational institution, or branch
16 of state, city, urban-county, charter county, county, or consolidated local
17 government shall be considered a proper cost of administration.

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

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

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

1 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of
2 State Health Insurance Subscribers to advise the secretary or his designee regarding
3 the state-sponsored health insurance program for employees. The secretary shall
4 appoint, from a list of names submitted by appointing authorities, members
5 representing school districts from each of the seven (7) Supreme Court districts,
6 members representing state government from each of the seven (7) Supreme Court
7 districts, two (2) members representing retirees under age sixty-five (65), one (1)
8 member representing local health departments, two (2) members representing the
9 Kentucky Teachers' Retirement System, and three (3) members at large. The
10 secretary shall also appoint two (2) members from a list of five (5) names submitted
11 by the Kentucky Education Association, two (2) members from a list of five (5)
12 names submitted by the largest state employee organization of nonschool state
13 employees, two (2) members from a list of five (5) names submitted by the
14 Kentucky Association of Counties, two (2) members from a list of five (5) names
15 submitted by the Kentucky League of Cities, and two (2) members from a list of
16 names consisting of five (5) names submitted by each state employee organization
17 that has two thousand (2,000) or more members on state payroll deduction. The
18 advisory committee shall be appointed in January of each year and shall meet
19 quarterly.

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

25 (11) Interruption of an established treatment regime with maintenance drugs shall be
26 grounds for an insured to appeal a formulary change through the established appeal
27 procedures approved by the Department of Insurance, if the physician supervising

1 the treatment certifies that the change is not in the best interests of the patient.

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

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

14 (b) A health insurer shall not discriminate against any retail pharmacy located
15 within the geographic coverage area of the health benefit plan and that meets
16 the terms and conditions for participation established by the insurer, including
17 price, dispensing fee, and copay requirements of a mail-order option. The
18 retail pharmacy shall not be required to dispense by mail.

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

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

26 (15) Any policy provided to state employees or their dependents pursuant to this section
27 shall provide coverage for the diagnosis and treatment of autism spectrum disorders

- 1 consistent with KRS 304.17A-142.
- 2 (16) Any policy provided to state employees or their dependents pursuant to this section
3 shall provide coverage for obtaining amino acid-based elemental formula pursuant
4 to KRS 304.17A-258.
- 5 (17) If a state employee's residence and place of employment are in the same county, and
6 if the hospital located within that county does not offer surgical services, intensive
7 care services, obstetrical services, level II neonatal services, diagnostic cardiac
8 catheterization services, and magnetic resonance imaging services, the employee
9 may select a plan available in a contiguous county that does provide those services,
10 and the state contribution for the plan shall be the amount available in the county
11 where the plan selected is located.
- 12 (18) If a state employee's residence and place of employment are each located in counties
13 in which the hospitals do not offer surgical services, intensive care services,
14 obstetrical services, level II neonatal services, diagnostic cardiac catheterization
15 services, and magnetic resonance imaging services, the employee may select a plan
16 available in a county contiguous to the county of residence that does provide those
17 services, and the state contribution for the plan shall be the amount available in the
18 county where the plan selected is located.
- 19 (19) The Personnel Cabinet is encouraged to study whether it is fair and reasonable and
20 in the best interests of the state group to allow any carrier bidding to offer health
21 care coverage under this section to submit bids that may vary county by county or
22 by larger geographic areas.
- 23 (20) Notwithstanding any other provision of this section, the bid for proposals for health
24 insurance coverage for calendar year 2004 shall include a bid scenario that reflects
25 the statewide rating structure provided in calendar year 2003 and a bid scenario that
26 allows for a regional rating structure that allows carriers to submit bids that may
27 vary by region for a given product offering as described in this subsection:

- 1 (a) The regional rating bid scenario shall not include a request for bid on a
2 statewide option;
- 3 (b) The Personnel Cabinet shall divide the state into geographical regions which
4 shall be the same as the partnership regions designated by the Department for
5 Medicaid Services for purposes of the Kentucky Health Care Partnership
6 Program established pursuant to 907 KAR 1:705;
- 7 (c) The request for proposal shall require a carrier's bid to include every county
8 within the region or regions for which the bid is submitted and include but not
9 be restricted to a preferred provider organization (PPO) option;
- 10 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the
11 carrier all of the counties included in its bid within the region. If the Personnel
12 Cabinet deems the bids submitted in accordance with this subsection to be in
13 the best interests of state employees in a region, the cabinet may award the
14 contract for that region to no more than two (2) carriers; and
- 15 (e) Nothing in this subsection shall prohibit the Personnel Cabinet from including
16 other requirements or criteria in the request for proposal.
- 17 (21) Any fully insured health benefit plan or self-insured plan issued or renewed on or
18 after July 12, 2006, to public employees pursuant to this section which provides
19 coverage for services rendered by a physician or osteopath duly licensed under KRS
20 Chapter 311 that are within the scope of practice of an optometrist duly licensed
21 under the provisions of KRS Chapter 320 shall provide the same payment of
22 coverage to optometrists as allowed for those services rendered by physicians or
23 osteopaths.
- 24 (22) Any fully insured health benefit plan or self-insured plan issued or renewed on or
25 after July 12, 2006, to public employees pursuant to this section shall comply with
26 the provisions of KRS 304.17A-270 and 304.17A-525.
- 27 (23) Any fully insured health benefit plan or self -insured plan issued or renewed on or

1 after July 12, 2006, to public employees shall comply with KRS 304.17A-600 to
 2 304.17A-633 pertaining to utilization review, KRS 205.593 and 304.17A-700 to
 3 304.17A-730 pertaining to payment of claims, KRS 304.14-135 pertaining to
 4 uniform health insurance claim forms, KRS 304.17A-580 and 304.17A-641
 5 pertaining to emergency medical care, KRS 304.99-123, and any administrative
 6 regulations promulgated thereunder.

7 (24) Any fully insured health benefit plan or self-insured plan issued or renewed on or
 8 after July 1, 2019, to public employees pursuant to this section shall comply with
 9 KRS 304.17A-138.

10 **(25) Any fully insured health benefit plan or self-insured plan issued or renewed on or**
 11 **after the effective date of this Act, to public employees pursuant to this section**
 12 **shall:**

13 **(a) Comply with Section 1 of this Act; and**

14 **(b) Provide access to:**

15 **1. Health care providers that practice in the area of prosthetics and**
 16 **orthotics; and**

17 **2. At least two (2) distinct professionals that provide devices and services**
 18 **covered under Section 1 of this Act.**

19 ➔Section 5. KRS 205.560 is amended to read as follows:

20 (1) The scope of medical care for which the Cabinet for Health and Family Services
 21 undertakes to pay shall be designated and limited by regulations promulgated by the
 22 cabinet, pursuant to the provisions in this section. Within the limitations of any
 23 appropriation therefor, the provision of complete upper and lower dentures to
 24 recipients of Medical Assistance Program benefits who have their teeth removed by
 25 a dentist resulting in the total absence of teeth shall be a mandatory class in the
 26 scope of medical care. Payment to a dentist of any Medical Assistance Program
 27 benefits for complete upper and lower dentures shall only be provided on the

1 condition of a preauthorized agreement between an authorized representative of the
2 Medical Assistance Program and the dentist prior to the removal of the teeth. The
3 selection of another class or other classes of medical care shall be recommended by
4 the council to the secretary for health and family services after taking into
5 consideration, among other things, the amount of federal and state funds available,
6 the most essential needs of recipients, and the meeting of such need on a basis
7 insuring the greatest amount of medical care as defined in KRS 205.510 consonant
8 with the funds available, including but not limited to the following categories,
9 except where the aid is for the purpose of obtaining an abortion:

- 10 (a) Hospital care, including drugs, and medical supplies and services during any
11 period of actual hospitalization;
- 12 (b) Nursing-home care, including medical supplies and services, and drugs during
13 confinement therein on prescription of a physician, dentist, or podiatrist;
- 14 (c) Drugs, nursing care, medical supplies, and services during the time when a
15 recipient is not in a hospital but is under treatment and on the prescription of a
16 physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall
17 include products for the treatment of inborn errors of metabolism or genetic,
18 gastrointestinal, and food allergic conditions, consisting of therapeutic food,
19 formulas, supplements, amino acid-based elemental formula, or low-protein
20 modified food products that are medically indicated for therapeutic treatment
21 and are administered under the direction of a physician, and include but are
22 not limited to the following conditions:

- 23 1. Phenylketonuria;
- 24 2. Hyperphenylalaninemia;
- 25 3. Tyrosinemia (types I, II, and III);
- 26 4. Maple syrup urine disease;
- 27 5. A-ketoacid dehydrogenase deficiency;

- 1 6. Isovaleryl-CoA dehydrogenase deficiency;
- 2 7. 3-methylcrotonyl-CoA carboxylase deficiency;
- 3 8. 3-methylglutaconyl-CoA hydratase deficiency;
- 4 9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase
- 5 deficiency);
- 6 10. B-ketothiolase deficiency;
- 7 11. Homocystinuria;
- 8 12. Glutaric aciduria (types I and II);
- 9 13. Lysinuric protein intolerance;
- 10 14. Non-ketotic hyperglycinemia;
- 11 15. Propionic acidemia;
- 12 16. Gyrate atrophy;
- 13 17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
- 14 18. Carbamoyl phosphate synthetase deficiency;
- 15 19. Ornithine carbamoyl transferase deficiency;
- 16 20. Citrullinemia;
- 17 21. Arginosuccinic aciduria;
- 18 22. Methylmalonic acidemia;
- 19 23. Argininemia;
- 20 24. Food protein allergies;
- 21 25. Food protein-induced enterocolitis syndrome;
- 22 26. Eosinophilic disorders; and
- 23 27. Short bowel syndrome;
- 24 (d) Physician, podiatric, and dental services;
- 25 (e) **Prosthetic and orthotic devices and services, which shall:**
- 26 **1. At a minimum, meet the coverage requirements in Section 1 of this**
- 27 **Act; and**

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2. Include access to:

a. Health care providers that practice in the area of prosthetics and orthotics; and

b. At least two (2) distinct professionals that provide devices and services covered under Section 1 of this Act;

(f) Optometric services for all age groups shall be limited to prescription services, services to frames and lenses, and diagnostic services provided by an optometrist, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses shall be provided only to children under age twenty-one (21);

(g)~~(f)~~ Drugs on the prescription of a physician used to prevent the rejection of transplanted organs if the patient is indigent; and

(h)~~(g)~~ Nonprofit neighborhood health organizations or clinics where some or all of the medical services are provided by licensed registered nurses or by advanced medical students presently enrolled in a medical school accredited by the Association of American Medical Colleges and where the students or licensed registered nurses are under the direct supervision of a licensed physician who rotates his services in this supervisory capacity between two (2) or more of the nonprofit neighborhood health organizations or clinics specified in this paragraph.

(2) Payments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies. It shall be one (1) of the functions of the council to make recommendations to the Cabinet for Health and Family Services with respect to the bases for payment. In determining the rates of reimbursement for long-term-care facilities participating in the Medical Assistance

1 Program, the Cabinet for Health and Family Services shall, to the extent permitted
2 by federal law, not allow the following items to be considered as a cost to the
3 facility for purposes of reimbursement:

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

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

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

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

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

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

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

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

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

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

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

- 1 deny, or approve and issue a Provider Identification Number (PID) within
2 fifteen (15) business days from the time all necessary completed enrollment
3 forms have been submitted and all outstanding accounts receivable have been
4 satisfied.
- 5 (b) Within forty-five (45) days of receiving a correct and complete provider
6 application, the Department for Medicaid Services shall complete the
7 enrollment process by either denying or approving and issuing a Provider
8 Identification Number (PID) for a behavioral health provider who provides
9 substance use disorder services, unless the department notifies the provider
10 that additional time is needed to render a decision for resolution of an issue or
11 dispute.
- 12 (c) Within forty-five (45) days of receipt of a correct and complete application for
13 credentialing by a behavioral health provider providing substance use disorder
14 services, a Medicaid managed care organization shall complete its contracting
15 and credentialing process, unless the Medicaid managed care organization
16 notifies the provider that additional time is needed to render a decision. If
17 additional time is needed, the Medicaid managed care organization shall not
18 take any longer than ninety (90) days from receipt of the credentialing
19 application to deny or approve and contract with the provider.
- 20 (d) A Medicaid managed care organization shall adjudicate any clean claims
21 submitted for a substance use disorder service from an enrolled and
22 credentialed behavioral health provider who provides substance use disorder
23 services in accordance with KRS 304.17A-700 to 304.17A-730.
- 24 (e) The Department of Insurance may impose a civil penalty of one hundred
25 dollars (\$100) per violation when a Medicaid managed care organization fails
26 to comply with this section. Each day that a Medicaid managed care
27 organization fails to pay a claim may count as a separate violation.

- 1 (13) Dentists licensed under KRS Chapter 313 shall be excluded from the requirements
2 of subsection (12) of this section. The Department for Medicaid Services shall
3 develop a specific form and establish guidelines for assessing the credentials of
4 dentists applying for participation in the Medical Assistance Program.
5 ➔Section 6. This Act takes effect on January 1, 2021.