CHAPTER 62

(SB 55)

AN ACT relating to copayments by medical assistance recipients.

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

➔Section 1. KRS 205.6312 is amended to read as follows:

~~[(1)]~~***Notwithstanding any state law to the contrary,*** the cabinet ***or a managed care organization contracted by the cabinet to provide Medicaid services pursuant to this chapter*** shall ***not*** institute ~~[nominal]~~copayments***, cost sharing,*** or similar charges to be paid by ***any*** medical assistance recipients, their spouses, or parents, ***for any assistance provided pursuant to this chapter, federal law, or any federal Medicaid waiver***~~[under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o]~~.

~~[(2) Copayments or similar charges shall not be imposed for the following services:~~

~~(a) All services provided to children under eighteen (18) years of age;~~

~~(b) All services furnished to pregnant women, if the services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;~~

~~(c) Emergency services including hospital, clinic, office, or other facility services which are necessary to prevent the death or serious impairment of the individual;~~

~~(d) Services furnished to institutionalized individuals if the individual is required, as a condition of receiving services, to spend all but a minimal amount of income for personal needs;~~

~~(e) Services furnished for an individual who is receiving hospice care as defined under Section 1905 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396d(o); and~~

~~(f) Other services excluded from cost sharing by federal law or regulation.~~

~~(3) Standard nominal copayments per service, not to exceed amounts allowable under Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o shall be collected by the provider and charged for the following services:~~

~~(a) Ambulance services which are provided to recipients in need of nonemergency health transportation services;~~

~~(b) Nonemergency services delivered in a hospital emergency room; and~~

~~(c) Prescription and over the counter drugs, subject to the limitation under subsection (6) of this section.~~

~~(4) No provider participating in the Medical Assistance Program shall deny services to any eligible recipient due to the inability of a recipient to make the required copayment. This provision shall not excuse the recipient from liability for payment of the charge.~~

~~(5) The cabinet shall promulgate administrative regulations under KRS Chapter 13A to implement the provisions of this section.~~

~~(6) Any copayment for a prescription or over the counter drug shall not exceed one dollar ($1).]~~

➔Section 2. KRS 205.6485 is amended to read as follows:

(1) The Cabinet for Health and Family Services shall prepare a state child health plan meeting the requirements of Title XXI of the Federal Social Security Act, for submission to the Secretary of the United States Department of Health and Human Services within such time as will permit the state to receive the maximum amounts of federal matching funds available under Title XXI. The cabinet shall, by administrative regulation promulgated in accordance with KRS Chapter 13A, establish the following:

(a) The eligibility criteria for children covered by the Kentucky Children's Health Insurance Program. However, no person eligible for services under Title XIX of the Social Security Act 42 U.S.C. 1396 to 1396v, as amended, shall be eligible for services under the Kentucky Children's Health Insurance Program except to the extent that Title XIX coverage is expanded by KRS 205.6481 to 205.6495 and KRS 304.17A-340;

(b) The schedule of benefits to be covered by the Kentucky Children's Health Insurance Program, which shall include preventive services, vision services including glasses, and dental services including at least sealants, extractions, and fillings, and which shall be at least equivalent to one (1) of the following:

1. The standard Blue Cross/Blue Shield preferred provider option under the Federal Employees Health Benefit Plan established by U.S.C. sec. 8903(1);

2. A mid-range health benefit coverage plan that is offered and generally available to state employees; or

3. Health insurance coverage offered by a health maintenance organization that has the largest insured commercial, non-Medicaid enrollment of covered lives in the state;

(c) The premium contribution per family of health insurance coverage available under the Kentucky Children's Health Insurance Program with provisions for the payment of premium contributions by families of children eligible for coverage by the program based upon a sliding scale relating to family income. Premium contributions shall be based on a six (6) month period not to exceed:

1. Ten dollars ($10), to be paid by a family with income between one hundred percent (100%) to one hundred thirty-three percent (133%) of the federal poverty level;

2. Twenty dollars ($20), to be paid by a family with income between one hundred thirty-four percent (134%) to one hundred forty-nine percent (149%) of the federal poverty level; and

3. One hundred twenty dollars ($120), to be paid by a family with income between one hundred fifty percent (150%) to two hundred percent (200%) of the federal poverty level, and which may be made on a partial payment plan of twenty dollars ($20) per month or sixty dollars ($60) per quarter;

(d) ***There shall be no*** ~~[The level of]~~ copayments for services provided under the Kentucky Children's Health Insurance Program~~[that shall not exceed those allowed by federal law]~~; and

(e) The criteria for health services providers and insurers wishing to contract with the Commonwealth to provide the children's health insurance coverage. However, the cabinet shall provide, in any contracting process for the preventive health insurance program, the opportunity for a public health department to bid on preventive health services to eligible children within the public health department's service area. A public health department shall not be disqualified from bidding because the department does not currently offer all the services required by paragraph (b) of this subsection. The criteria shall be set forth in administrative regulations under KRS Chapter 13A and shall maximize competition among the providers and insurers. The Cabinet for Finance and Administration shall provide oversight over contracting policies and procedures to assure that the number of applicants for contracts is maximized.

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

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

➔Section 3. KRS 205.5591 is amended to read as follows:

(1) The cabinet shall provide oversight, guidance, and direction to Medicaid providers delivering care using telehealth as defined in KRS 205.510.

(2) The cabinet shall:

(a) Develop policies and procedures to ensure the proper use and security for telehealth, including but not limited to confidentiality and data integrity, privacy and security, informed consent, privileging and credentialing, reimbursement, and technology;

(b) Promote access to health care provided via telehealth;

(c) Maintain a list of Medicaid providers who may deliver telehealth services to Medicaid recipients throughout the Commonwealth;

(d) Require that specialty care be rendered by a health care provider who is recognized and actively participating in the Medicaid program; and

(e) Require that any required prior authorization requesting a referral or consultation for specialty care be processed by the patient's primary care provider and that any specialist coordinate care with the patient's primary care provider.

(3) The cabinet or a Medicaid managed care organization shall not:

(a) Require a Medicaid provider to be physically present with a Medicaid recipient, unless the provider determines that it is medically necessary to perform those services in person;

(b) Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in person;

(c) Require a Medicaid provider to be employed by another provider or agency in order to provide telehealth services that would not be required if that service were provided in person;

(d) Require demonstration that it is necessary to provide services to a Medicaid recipient through telehealth;

(e) Restrict or deny coverage of telehealth based solely on the communication technology or application used to deliver the telehealth services; or

(f) Require a Medicaid provider to be part of a telehealth network.

(4) The Medicaid program or a Medicaid managed care organization shall require a telehealth provider to be licensed in Kentucky in order to receive reimbursement for telehealth services.

(5) The Medicaid program or a Medicaid managed care organization shall reimburse for covered services provided to a Medicaid recipient through telehealth, as defined in KRS 205.510. The department shall promulgate administrative regulations to establish requirements for telehealth coverage and reimbursement, which shall be equivalent to the coverage for the same service provided in person unless the telehealth provider and the Medicaid program or a Medicaid managed care organization contractually agree to a lower reimbursement rate for telehealth services, or the department establishes a different reimbursement rate.

(6) ~~[Benefits for a service provided to a Medicaid recipient through telehealth may be made subject to a deductible, copayment, or coinsurance requirement. A deductible, copayment, or coinsurance applicable to a particular service provided through telehealth shall not exceed the deductible, copayment, or coinsurance required by the Medicaid program for the same service provided in person.~~

~~(7)]~~Nothing in this section shall be construed to require the Medicaid program or a Medicaid managed care organization to:

(a) Provide coverage for telehealth services that are not medically necessary; or

(b) Reimburse any fees charged by a telehealth facility for transmission of a telehealth encounter.

(7) ~~[(8)]~~ The cabinet shall maintain telehealth policies and guidelines to providing care that ensure that Medicaid-eligible citizens will have safe, adequate, and efficient medical care, and that prevent waste, fraud, and abuse of the Medicaid program.

Signed by Governor March 22, 2021.