CHAPTER 201

(SB 51)

AN ACT relating to addiction treatment.

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

➔Section 1. KRS 304.17A-611 is amended to read as follows:

(1) A utilization review decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the insurer or its designee for those services, unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person, authorized person, or the provider.

(2) For health benefit plans issued or renewed on or after the effective date of this section, an insurer shall not require or conduct a prospective or concurrent review for a prescription drug:

(a) That:

1. Is used in the treatment of alcohol or opioid use disorder; and

2. Contains Methadone, Buprenorphine, or Naltrexone; or

(b) That was approved before the effective date of this section by the United States Food and Drug Administration for the mitigation of opioid withdrawal symptoms.

➔Section 2. KRS 205.536 is amended to read as follows:

(1) A Medicaid managed care organization shall have a utilization review plan, as defined in KRS 304.17A-600, that meets the requirements established in 42 C.F.R. pts. 431, 438, and 456. If the Medicaid managed care organization utilizes a private review agent, as defined in KRS 304.17A-600, the agent shall comply with all applicable requirements of KRS 304.17A-600 to 304.17A-633.

(2) In conducting utilization reviews for Medicaid benefits, each Medicaid managed care organization shall use the medical necessity criteria selected by the Department of Insurance pursuant to KRS 304.38-240, for making determinations of medical necessity and clinical appropriateness pursuant to the utilization review plan required by subsection (1) of this section.

(3) To the extent consistent with the federal regulations referenced in subsection (1) of this section, the Department for Medicaid Services or any managed care organization contracted to provide Medicaid benefits pursuant to KRS Chapter 205 shall not require or conduct a prospective or concurrent review, as defined in KRS 304.17A-600, for a prescription drug:

(a) That:

1. Is used in the treatment of alcohol or opioid use disorder; and

2. Contains Methadone, Buprenorphine, or Naltrexone; or

(b) That was approved before January 1, 2022, by the United States Food and Drug Administration for the mitigation of opioid withdrawal symptoms.

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

(1) As used in this section:

(a) "Kentucky Board of Nursing" means the board established in KRS 314.121; and

(b) "State Board of Medical Licensure" means the board established in KRS 311.530.

(2) For all claims made during the preceding plan year, an insurer shall annually report to the commissioner the number and type of providers that have prescribed medication for addiction treatment to its insureds:

(a) In conjunction with behavioral therapy; and

(b) Not in conjunction with behavioral therapy.

(3) The commissioner shall submit an annual written report, which shall include an executive summary, on the information reported under subsection (2) of this section to:

(a) The General Assembly;

(b) The State Board of Medical Licensure; and

(c) The Kentucky Board of Nursing.

➔Section 4. KRS 205.522 is amended to read as follows:

(1) The Department for Medicaid Services and any managed care organization contracted to provide Medicaid benefits pursuant to this chapter shall comply with the provisions of KRS 304.17A-167, 304.17A-235, 304.17A-515, 304.17A-580, 304.17A-600, 304.17A-603, 304.17A-607, and 304.17A-740 to 304.17A-743, as applicable.

(2) A managed care organization contracted to provide Medicaid benefits pursuant to this chapter shall comply with the reporting requirements of Section 3 of this Act.

➔SECTION 5. A NEW SECTION OF KRS CHAPTER 222 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "third-party payor" means any person required to comply with subsection (2) of Section 1 of this Act or subsection (3) of Section 2 of this Act.

(2) Prior to the discharge of a patient that has received medication for addiction- treatment, the treating facility shall submit a written discharge plan to the patient, and the patient's third-party payor, if any, which shall describe arrangements for additional services needed following discharge.

➔Section 6. In implementing Section 2 of this Act, if the Cabinet for Health and Family Services or the Department for Medicaid Services determines that a waiver or any other authorization is necessary to take advantage of all federal funds that may be available, the cabinet or department shall:

(1) Within 90 days of the effective date of Section 2 of this Act, apply for the waiver or authorization;

(2) Notify in writing the co-chairs of the Interim Joint Committee on Health, Welfare, and Family Services within 2 business days of the submission of the application; and

(3) Pursuant to KRS 205.525, provide an update, on or before December 1, 2021, on the status of the application to the Interim Joint Committee on Health, Welfare, and Family Services.

➔Section 7. Section 1 of this Act takes effect January 1, 2022.

Signed by Governor April 8, 2021.