

1 AN ACT relating to infertility treatment coverage.

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) All health benefit plan issued or renewed on or after the effective date of this Act*  
6 *shall provide coverage for the diagnosis and treatment of infertility, including but*  
7 *not limited to coverage for:*

8 *(a) Diagnostic tests and procedures, including but not limited to:*

9 *1. Hysterosalpingogram;*

10 *2. Hysteroscopy;*

11 *3. Endometrial biopsy;*

12 *4. Laparoscopy;*

13 *5. Sonohysterogram;*

14 *6. Postcoital tests;*

15 *7. Testis biopsy;*

16 *8. Semen analysis;*

17 *9. Blood tests; and*

18 *10. Ultrasounds; and*

19 *(b) Prescription drugs approved by the United States Food and Drug*  
20 *Administration for use in the diagnosis and treatment of infertility in*  
21 *accordance with subsection (3) of this section.*

22 *(2) Coverage required by subsection (1) of this section, including required coverage*  
23 *for prescription drugs:*

24 *(a) Shall be limited to:*

25 *1. Insured whose ages range from twenty-one (21) through forty-four*  
26 *(44) years. Nothing in this paragraph shall preclude the provision of*  
27 *the coverage to persons who are younger than twenty-one (21) or older*

1 than forty-four (44) years;

2 2. Insureds who have been previously covered under the health benefit  
3 plan for a period of at least twelve (12) months. For the purposes of  
4 this paragraph, "period of at least twelve (12) months" shall be  
5 determined by calculating the time either from the date the insured  
6 was first covered under the plan or from the date the insured was first  
7 covered by a previously in-force converted plan, whichever is earlier;  
8 and

9 3. Services prescribed as part of a physician's overall plan of care and  
10 consistent with the guidelines established pursuant to this section and  
11 Section 2 of this Act;

12 (b) May be subject to copayments, coinsurance, and deductibles as may be  
13 deemed appropriate by the commissioner, if they are consistent with those  
14 established for other benefits within the health benefit plan; and

15 (c) Shall not include:

16 1. In vitro fertilization;

17 2. Gamete intrafallopian tube transfers or zygote intrafallopian tube  
18 transfers;

19 3. The reversal of elective sterilizations; or

20 4. Medical or surgical services or procedures that are deemed to be  
21 experimental in accordance with clinical guidelines established  
22 pursuant to this section and Section 2 of this Act.

23 (3) The commissioner shall, by promulgation of administrative regulations, stipulate  
24 guidelines and standards which shall be used in carrying out the provisions of  
25 this section. These guidelines and standards shall include:

26 (a) The determination of "infertility" in accordance with the standards and  
27 guidelines established and adopted by the American College of

1           *Obstetricians and Gynecologists and the American Society for Reproductive*  
 2           *Medicine; and*

3           *(b) The identification of experimental procedures and treatments not covered*  
 4           *for the diagnosis and treatment of infertility determined in accordance with*  
 5           *the standards and guidelines established and adopted by the American*  
 6           *College of Obstetricians and Gynecologists and the American Society for*  
 7           *Reproductive Medicine.*

8           *(4) All health benefit plans issued or renewed on or after the effective date of this Act*  
 9           *shall not deny coverage for health care services otherwise covered by the health*  
 10           *benefit plan solely because the services may result in infertility.*

11           ➔SECTION 2. A NEW SECTION OF KRS 311.530 TO 311.620 IS CREATED  
 12 TO READ AS FOLLOWS:

13           *The board shall, by promulgation of administrative regulations, stipulate guidelines*  
 14           *and standards which shall be used in carrying out the practice of medicine or*  
 15           *osteopathy relating to services covered by Section 1 of this Act. These guidelines and*  
 16           *standards shall include:*

17           *(1) Required training, experience, and other standards for health care providers for*  
 18           *the provision of procedures and treatments for the diagnosis and treatment of*  
 19           *infertility determined in accordance with the standards and guidelines established*  
 20           *and adopted by the American College of Obstetricians and Gynecologists and the*  
 21           *American Society for Reproductive Medicine; and*

22           *(2) The determination of appropriate medical candidates by the treating physician in*  
 23           *accordance with the standards and guidelines established and adopted by the*  
 24           *American College of Obstetricians and Gynecologists and the American Society*  
 25           *for Reproductive Medicine.*

26           ➔Section 3. KRS 18A.225 is amended to read as follows:

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

- 1           1. Any person, including an elected public official, who is regularly  
2           employed by any department, office, board, agency, or branch of state  
3           government; or by a public postsecondary educational institution; or by  
4           any city, urban-county, charter county, county, or consolidated local  
5           government, whose legislative body has opted to participate in the state-  
6           sponsored health insurance program pursuant to KRS 79.080; and who  
7           is either a contributing member to any one (1) of the retirement systems  
8           administered by the state, including but not limited to the Kentucky  
9           Retirement Systems, Kentucky Teachers' Retirement System, the  
10          Legislators' Retirement Plan, or the Judicial Retirement Plan; or is  
11          receiving a contractual contribution from the state toward a retirement  
12          plan; or, in the case of a public postsecondary education institution, is an  
13          individual participating in an optional retirement plan authorized by  
14          KRS 161.567;
- 15          2. Any certified or classified employee of a local board of education;
- 16          3. Any elected member of a local board of education;
- 17          4. Any person who is a present or future recipient of a retirement  
18          allowance from the Kentucky Retirement Systems, Kentucky Teachers'  
19          Retirement System, the Legislators' Retirement Plan, the Judicial  
20          Retirement Plan, or the Kentucky Community and Technical College  
21          System's optional retirement plan authorized by KRS 161.567, except  
22          that a person who is receiving a retirement allowance and who is age  
23          sixty-five (65) or older shall not be included, with the exception of  
24          persons covered under KRS 61.702(4)(c), 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 (20) of this section, any carrier bidding to offer health  
16 care coverage to employees shall also agree to rate all employees as a single  
17 entity, except for those retirees whose former employers insure their active  
18 employees outside the state-sponsored health insurance program.

19 (d) Any carrier bidding to offer health care coverage to employees shall agree to  
20 provide enrollment, claims, and utilization data to the Commonwealth in a  
21 format specified by the Personnel Cabinet with the understanding that the data  
22 shall be owned by the Commonwealth; to provide data in an electronic form  
23 and within a time frame specified by the Personnel Cabinet; and to be subject  
24 to penalties for noncompliance with data reporting requirements as specified  
25 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions  
26 to protect the confidentiality of each individual employee; however,  
27 confidentiality assertions shall not relieve a carrier from the requirement of

- 1 providing stipulated data to the Commonwealth.
- 2 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities  
3 for timely analysis of data received from carriers and, to the extent possible,  
4 provide in the request-for-proposal specifics relating to data requirements,  
5 electronic reporting, and penalties for noncompliance. The Commonwealth  
6 shall own the enrollment, claims, and utilization data provided by each carrier  
7 and shall develop methods to protect the confidentiality of the individual. The  
8 Personnel Cabinet shall include in the October annual report submitted  
9 pursuant to the provisions of KRS 18A.226 to the Governor, the General  
10 Assembly, and the Chief Justice of the Supreme Court, an analysis of the  
11 financial stability of the program, which shall include but not be limited to  
12 loss ratios, methods of risk adjustment, measurements of carrier quality of  
13 service, prescription coverage and cost management, and statutorily required  
14 mandates. If state self-insurance was available as a carrier option, the report  
15 also shall provide a detailed financial analysis of the self-insurance fund  
16 including but not limited to loss ratios, reserves, and reinsurance agreements.
- 17 (f) If any agency participating in the state-sponsored employee health insurance  
18 program for its active employees terminates participation and there is a state  
19 appropriation for the employer's contribution for active employees' health  
20 insurance coverage, then neither the agency nor the employees shall receive  
21 the state-funded contribution after termination from the state-sponsored  
22 employee health insurance program.
- 23 (g) Any funds in flexible spending accounts that remain after all reimbursements  
24 have been processed shall be transferred to the credit of the state-sponsored  
25 health insurance plan's appropriation account.
- 26 (h) Each entity participating in the state-sponsored health insurance program shall  
27 provide an amount at least equal to the state contribution rate for the employer

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

- 4   (3) The premiums may be paid by the policyholder:
- 5       (a) Wholly from funds contributed by the employee, by payroll deduction or  
6       otherwise;
- 7       (b) Wholly from funds contributed by any department, board, agency, public  
8       postsecondary education institution, or branch of state, city, urban-county,  
9       charter county, county, or consolidated local government; or
- 10      (c) Partly from each, except that any premium due for health care coverage or  
11      dental coverage, if any, in excess of the premium amount contributed by any  
12      department, board, agency, postsecondary education institution, or branch of  
13      state, city, urban-county, charter county, county, or consolidated local  
14      government for any other health care coverage shall be paid by the employee.
- 15   (4) If an employee moves his place of residence or employment out of the service area  
16      of an insurer offering a managed health care plan, under which he has elected  
17      coverage, into either the service area of another managed health care plan or into an  
18      area of the Commonwealth not within a managed health care plan service area, the  
19      employee shall be given an option, at the time of the move or transfer, to change his  
20      or her coverage to another health benefit plan.
- 21   (5) No payment of premium by any department, board, agency, public postsecondary  
22      educational institution, or branch of state, city, urban-county, charter county,  
23      county, or consolidated local government shall constitute compensation to an  
24      insured employee for the purposes of any statute fixing or limiting the  
25      compensation of such an employee. Any premium or other expense incurred by any  
26      department, board, agency, public postsecondary educational institution, or branch  
27      of state, city, urban-county, charter county, county, or consolidated local



1 government shall be considered a proper cost of administration.

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

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

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

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

1 that has two thousand (2,000) or more members on state payroll deduction. The  
2 advisory committee shall be appointed in January of each year and shall meet  
3 quarterly.

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

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

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

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

25 (b) A health insurer shall not discriminate against any retail pharmacy located  
26 within the geographic coverage area of the health benefit plan and that meets  
27 the terms and conditions for participation established by the insurer, including

1 price, dispensing fee, and copay requirements of a mail-order option. The  
2 retail pharmacy shall not be required to dispense by mail.

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

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

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

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

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

23 (15)~~(18)~~ If a state employee's residence and place of employment are each located in  
24 counties in which the hospitals do not offer surgical services, intensive care  
25 services, obstetrical services, level II neonatal services, diagnostic cardiac  
26 catheterization services, and magnetic resonance imaging services, the employee  
27 may select a plan available in a county contiguous to the county of residence that

1 does provide those services, and the state contribution for the plan shall be the  
2 amount available in the county where the plan selected is located.

3 ~~(16)~~~~(19)~~ The Personnel Cabinet is encouraged to study whether it is fair and reasonable  
4 and in the best interests of the state group to allow any carrier bidding to offer  
5 health care coverage under this section to submit bids that may vary county by  
6 county or by larger geographic areas.

7 ~~(17)~~~~(20)~~ Notwithstanding any other provision of this section, the bid for proposals for  
8 health insurance coverage for calendar year 2004 shall include a bid scenario that  
9 reflects the statewide rating structure provided in calendar year 2003 and a bid  
10 scenario that allows for a regional rating structure that allows carriers to submit bids  
11 that may vary by region for a given product offering as described in this subsection:

- 12 (a) The regional rating bid scenario shall not include a request for bid on a  
13 statewide option;
- 14 (b) The Personnel Cabinet shall divide the state into geographical regions which  
15 shall be the same as the partnership regions designated by the Department for  
16 Medicaid Services for purposes of the Kentucky Health Care Partnership  
17 Program established pursuant to 907 KAR 1:705;
- 18 (c) The request for proposal shall require a carrier's bid to include every county  
19 within the region or regions for which the bid is submitted and include but not  
20 be restricted to a preferred provider organization (PPO) option;
- 21 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the  
22 carrier all of the counties included in its bid within the region. If the Personnel  
23 Cabinet deems the bids submitted in accordance with this subsection to be in  
24 the best interests of state employees in a region, the cabinet may award the  
25 contract for that region to no more than two (2) carriers; and
- 26 (e) Nothing in this subsection shall prohibit the Personnel Cabinet from including  
27 other requirements or criteria in the request for proposal.

1 ~~(18)~~~~(21)~~ Any fully insured health benefit plan or self-insured plan issued or renewed on  
 2 or after the effective date of this Act~~[July 12, 2006,]~~ and provided to public  
 3 employees pursuant to this section shall:

4 (a) Provide coverage meeting the requirements of:

5 1. KRS 304.17A-132;

6 2. KRS 304.17A-142;

7 3. KRS 304.17A-258; and

8 4. Section 1 of this Act;

9 (b) If the plan~~[which]~~ provides coverage for services rendered by a physician or  
 10 osteopath duly licensed under KRS Chapter 311 that are within the scope of  
 11 practice of an optometrist duly licensed under the provisions of KRS Chapter  
 12 320,~~[shall]~~ provide the same payment of coverage to optometrists as allowed  
 13 for those services rendered by physicians or osteopaths; and

14 (c) Comply with the provisions of:

15 1. KRS 304.17A-270 and 304.17A-525; and

16 2. KRS 304.17A-600 to 304.17A-633 pertaining to utilization review,  
 17 KRS 205.593 and 304.17A-700 to 304.17A-730 pertaining to payment  
 18 of claims, KRS 304.14-135 pertaining to uniform health insurance  
 19 claim forms, KRS 304.17A-580 and 304.17A-641 pertaining to  
 20 emergency medical care, KRS 304.99-123, and any administrative  
 21 regulations promulgated pursuant to these sections.

22 ~~[(22) Any fully insured health benefit plan or self-insured plan issued or renewed on or~~  
 23 ~~after July 12, 2006, to public employees pursuant to this section shall comply with~~  
 24 ~~the provisions of KRS 304.17A-270 and 304.17A-525.~~

25 ~~(23) Any full insured health benefit plan or self insured plan issued or renewed on or~~  
 26 ~~after July 12, 2006, to public employees shall comply with KRS 304.17A-600 to~~  
 27 ~~304.17A-633 pertaining to utilization review, KRS 205.593 and 304.17A-700 to~~

1 ~~304.17A-730 pertaining to payment of claims, KRS 304.14-135 pertaining to~~  
2 ~~uniform health insurance claim forms, KRS 304.17A-580 and 304.17A-641~~  
3 ~~pertaining to emergency medical care, KRS 304.99-123, and any administrative~~  
4 ~~regulations promulgated thereunder.]~~

5 ➔Section 4. KRS 205.560 is amended to read as follows:

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

- 23 (a) Hospital care, including drugs, and medical supplies and services during any  
24 period of actual hospitalization;
- 25 (b) Nursing-home care, including medical supplies and services, and drugs during  
26 confinement therein on prescription of a physician, dentist, or podiatrist;
- 27 (c) Drugs, nursing care, medical supplies, and services during the time when a

1 recipient is not in a hospital but is under treatment and on the prescription of a  
2 physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall  
3 include products for the treatment of inborn errors of metabolism or genetic,  
4 gastrointestinal, and food allergic conditions, consisting of therapeutic food,  
5 formulas, supplements, amino acid-based elemental formula, or low-protein  
6 modified food products that are medically indicated for therapeutic treatment  
7 and are administered under the direction of a physician, and include but are  
8 not limited to the following conditions:

- 9 1. Phenylketonuria;
- 10 2. Hyperphenylalaninemia;
- 11 3. Tyrosinemia (types I, II, and III);
- 12 4. Maple syrup urine disease;
- 13 5. A-ketoacid dehydrogenase deficiency;
- 14 6. Isovaleryl-CoA dehydrogenase deficiency;
- 15 7. 3-methylcrotonyl-CoA carboxylase deficiency;
- 16 8. 3-methylglutaconyl-CoA hydratase deficiency;
- 17 9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase  
18 deficiency);
- 19 10. B-ketothiolase deficiency;
- 20 11. Homocystinuria;
- 21 12. Glutaric aciduria (types I and II);
- 22 13. Lysinuric protein intolerance;
- 23 14. Non-ketotic hyperglycinemia;
- 24 15. Propionic acidemia;
- 25 16. Gyrate atrophy;
- 26 17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
- 27 18. Carbamoyl phosphate synthetase deficiency;

- 1           19. Ornithine carbamoyl transferase deficiency;
- 2           20. Citrullinemia;
- 3           21. Arginosuccinic aciduria;
- 4           22. Methylmalonic acidemia;
- 5           23. Argininemia;
- 6           24. Food protein allergies;
- 7           25. Food protein-induced enterocolitis syndrome;
- 8           26. Eosinophilic disorders; and
- 9           27. Short bowel syndrome;
- 10         (d) Physician, podiatric, and dental services;
- 11         (e) Optometric services for all age groups shall be limited to prescription services,
- 12           services to frames and lenses, and diagnostic services provided by an
- 13           optometrist, to the extent the optometrist is licensed to perform the services
- 14           and to the extent the services are covered in the ophthalmologist portion of the
- 15           physician's program. Eyeglasses shall be provided only to children under age
- 16           twenty-one (21);
- 17         (f) Drugs on the prescription of a physician used to prevent the rejection of
- 18           transplanted organs if the patient is indigent;
- 19         (g) Nonprofit neighborhood health organizations or clinics where some or all of
- 20           the medical services are provided by licensed registered nurses or by advanced
- 21           medical students presently enrolled in a medical school accredited by the
- 22           Association of American Medical Colleges and where the students or licensed
- 23           registered nurses are under the direct supervision of a licensed physician who
- 24           rotates his services in this supervisory capacity between two (2) or more of the
- 25           nonprofit neighborhood health organizations or clinics specified in this
- 26           paragraph;
- 27         (h) Services provided by health-care delivery networks as defined in KRS



1 216.900;

2 (i) Services provided by midlevel health-care practitioners as defined in KRS  
3 216.900;~~and~~

4 (j) Smoking cessation treatment interventions or programs prescribed by a  
5 physician, advanced practice registered nurse, physician assistant, or dentist,  
6 including but not limited to counseling, telephone counseling through a  
7 quitline, recommendations to the recipient that smoking should be  
8 discontinued, and prescription and over-the-counter medications and nicotine  
9 replacement therapy approved by the United States Food and Drug  
10 Administration for smoking cessation; **and**

11 **(k) Medical care for the diagnosis and treatment of infertility meeting the**  
12 **requirements of Section 1 of this Act.**

13 (2) Payments for hospital care, nursing-home care, and drugs or other medical,  
14 ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount  
15 of the payment to the cost of providing the services or supplies. It shall be one (1) of  
16 the functions of the council to make recommendations to the Cabinet for Health and  
17 Family Services with respect to the bases for payment. In determining the rates of  
18 reimbursement for long-term-care facilities participating in the Medical Assistance  
19 Program, the Cabinet for Health and Family Services shall, to the extent permitted  
20 by federal law, not allow the following items to be considered as a cost to the  
21 facility for purposes of reimbursement:

22 (a) Motor vehicles that are not owned by the facility, including motor vehicles  
23 that are registered or owned by the facility but used primarily by the owner or  
24 family members thereof;

25 (b) The cost of motor vehicles, including vans or trucks, used for facility business  
26 shall be allowed up to fifteen thousand dollars (\$15,000) per facility, adjusted  
27 annually for inflation according to the increase in the consumer price index-u

1 for the most recent twelve (12) month period, as determined by the United  
2 States Department of Labor. Medically equipped motor vehicles, vans, or  
3 trucks shall be exempt from the fifteen thousand dollar (\$15,000) limitation.  
4 Costs exceeding this limit shall not be reimbursable and shall be borne by the  
5 facility. Costs for additional motor vehicles, not to exceed a total of three (3)  
6 per facility, may be approved by the Cabinet for Health and Family Services if  
7 the facility demonstrates that each additional vehicle is necessary for the  
8 operation of the facility as required by regulations of the cabinet;

9 (c) Salaries paid to immediate family members of the owner or administrator, or  
10 both, of a facility, to the extent that services are not actually performed and are  
11 not a necessary function as required by regulation of the cabinet for the  
12 operation of the facility. The facility shall keep a record of all work actually  
13 performed by family members;

14 (d) The cost of contracts, loans, or other payments made by the facility to owners,  
15 administrators, or both, unless the payments are for services which would  
16 otherwise be necessary to the operation of the facility and the services are  
17 required by regulations of the Cabinet for Health and Family Services. Any  
18 other payments shall be deemed part of the owner's compensation in  
19 accordance with maximum limits established by regulations of the Cabinet for  
20 Health and Family Services. Interest paid to the facility for loans made to a  
21 third party may be used to offset allowable interest claimed by the facility;

22 (e) Private club memberships for owners or administrators, travel expenses for  
23 trips outside the state for owners or administrators, and other indirect  
24 payments made to the owner, unless the payments are deemed part of the  
25 owner's compensation in accordance with maximum limits established by  
26 regulations of the Cabinet for Health and Family Services; and

27 (f) Payments made to related organizations supplying the facility with goods or

1 services shall be limited to the actual cost of the goods or services to the  
2 related organization, unless it can be demonstrated that no relationship  
3 between the facility and the supplier exists. A relationship shall be considered  
4 to exist when an individual, including brothers, sisters, father, mother, aunts,  
5 uncles, and in-laws, possesses a total of five percent (5%) or more of  
6 ownership equity in the facility and the supplying business. An exception to  
7 the relationship shall exist if fifty-one percent (51%) or more of the supplier's  
8 business activity of the type carried on with the facility is transacted with  
9 persons and organizations other than the facility and its related organizations.

10 (3) No vendor payment shall be made unless the class and type of medical care  
11 rendered and the cost basis therefor has first been designated by regulation.

12 (4) The rules and regulations of the Cabinet for Health and Family Services shall  
13 require that a written statement, including the required opinion of a physician, shall  
14 accompany any claim for reimbursement for induced premature births. This  
15 statement shall indicate the procedures used in providing the medical services.

16 (5) The range of medical care benefit standards provided and the quality and quantity  
17 standards and the methods for determining cost formulae for vendor payments  
18 within each category of public assistance and other recipients shall be uniform for  
19 the entire state, and shall be designated by regulation promulgated within the  
20 limitations established by the Social Security Act and federal regulations. It shall  
21 not be necessary that the amount of payments for units of services be uniform for  
22 the entire state but amounts may vary from county to county and from city to city, as  
23 well as among hospitals, based on the prevailing cost of medical care in each locale  
24 and other local economic and geographic conditions, except that insofar as allowed  
25 by applicable federal law and regulation, the maximum amounts reimbursable for  
26 similar services rendered by physicians within the same specialty of medical  
27 practice shall not vary according to the physician's place of residence or place of

- 1 practice, as long as the place of practice is within the boundaries of the state.
- 2 (6) Nothing in this section shall be deemed to deprive a woman of all appropriate  
3 medical care necessary to prevent her physical death.
- 4 (7) To the extent permitted by federal law, no medical assistance recipient shall be  
5 recertified as qualifying for a level of long-term care below the recipient's current  
6 level, unless the recertification includes a physical examination conducted by a  
7 physician licensed pursuant to KRS Chapter 311 or by an advanced practice  
8 registered nurse licensed pursuant to KRS Chapter 314 and acting under the  
9 physician's supervision.
- 10 (8) If payments made to community mental health centers, established pursuant to KRS  
11 Chapter 210, for services provided to the intellectually disabled exceed the actual  
12 cost of providing the service, the balance of the payments shall be used solely for  
13 the provision of other services to the intellectually disabled through community  
14 mental health centers.
- 15 (9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to  
16 recipients of medical assistance under Title XIX of the Social Security Act on July  
17 15, 1986, shall deny admission of a person to a bed certified for reimbursement  
18 under the provisions of the Medical Assistance Program solely on the basis of the  
19 person's paying status as a Medicaid recipient. No person shall be removed or  
20 discharged from any facility solely because they became eligible for participation in  
21 the Medical Assistance Program, unless the facility can demonstrate the resident or  
22 the resident's responsible party was fully notified in writing that the resident was  
23 being admitted to a bed not certified for Medicaid reimbursement. No facility may  
24 decertify a bed occupied by a Medicaid recipient or may decertify a bed that is  
25 occupied by a resident who has made application for medical assistance.
- 26 (10) Family-practice physicians practicing in geographic areas with no more than one (1)  
27 primary-care physician per five thousand (5,000) population, as reported by the

1 United States Department of Health and Human Services, shall be reimbursed one  
2 hundred twenty-five percent (125%) of the standard reimbursement rate for  
3 physician services.

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

8 (12) (a) The Medical Assistance Program shall use the appropriate form and  
9 guidelines for enrolling those providers applying for participation in the  
10 Medical Assistance Program, including those licensed and regulated under  
11 KRS Chapters 311, 312, 314, 315, and 320, any facility required to be  
12 licensed pursuant to KRS Chapter 216B, and any other health care practitioner  
13 or facility as determined by the Department for Medicaid Services through an  
14 administrative regulation promulgated under KRS Chapter 13A. A Medicaid  
15 managed care organization shall use the forms and guidelines established  
16 under KRS 304.17A-545(5) to credential a provider. For any provider who  
17 contracts with and is credentialed by a Medicaid managed care organization  
18 prior to enrollment, the cabinet shall complete the enrollment process and  
19 deny, or approve and issue a Provider Identification Number (PID) within  
20 fifteen (15) business days from the time all necessary completed enrollment  
21 forms have been submitted and all outstanding accounts receivable have been  
22 satisfied.

23 (b) Within forty-five (45) days of receiving a correct and complete provider  
24 application, the Department for Medicaid Services shall complete the  
25 enrollment process by either denying or approving and issuing a Provider  
26 Identification Number (PID) for a behavioral health provider who provides  
27 substance use disorder services, unless the department notifies the provider

1           that additional time is needed to render a decision for resolution of an issue or  
2           dispute.

3           (c) Within forty-five (45) days of receipt of a correct and complete application for  
4           credentialing by a behavioral health provider providing substance use disorder  
5           services, a Medicaid managed care organization shall complete its contracting  
6           and credentialing process, unless the Medicaid managed care organization  
7           notifies the provider that additional time is needed to render a decision. If  
8           additional time is needed, the Medicaid managed care organization shall not  
9           take any longer than ninety (90) days from receipt of the credentialing  
10          application to deny or approve and contract with the provider.

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

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

19          (13) Dentists licensed under KRS Chapter 313 shall be excluded from the requirements  
20          of subsection (12) of this section. The Department for Medicaid Services shall  
21          develop a specific form and establish guidelines for assessing the credentials of  
22          dentists applying for participation in the Medical Assistance Program.

23          ➔Section 5. This Act takes effect January 1, 2019.