

1 AN ACT relating to required Medicaid coverage of services.

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

3 ➔Section 1. KRS 205.560 is amended to read as follows:

- 4 (1) The scope of medical care for which the Cabinet for Health and Family Services
5 undertakes to pay shall be designated and limited by regulations promulgated by the
6 cabinet, pursuant to the provisions in this section, ***except that dental and***
7 ***optometric services provided to eligible recipients ages twenty-one (21) and over***
8 ***shall be the same as dental and optometric services required by federal law to be***
9 ***provided to eligible children under age twenty-one (21) and nonemergency***
10 ***medical transportation services for Medicaid-eligible recipients traveling to or***
11 ***from Medicaid-covered and medical necessary services for which appropriate free***
12 ***transportation is not available shall be provided.*** Within the limitations of any
13 appropriation therefor, the provision of complete upper and lower dentures to
14 recipients of Medical Assistance Program benefits who have their teeth removed by
15 a dentist resulting in the total absence of teeth shall be a mandatory class in the
16 scope of medical care. Payment to a dentist of any Medical Assistance Program
17 benefits for complete upper and lower dentures shall only be provided on the
18 condition of a preauthorized agreement between an authorized representative of the
19 Medical Assistance Program and the dentist prior to the removal of the teeth. The
20 selection of another class or other classes of medical care shall be recommended by
21 the council to the secretary for health and family services after taking into
22 consideration, among other things, the amount of federal and state funds available,
23 the most essential needs of recipients, and the meeting of such need on a basis
24 insuring the greatest amount of medical care as defined in KRS 205.510 consonant
25 with the funds available, including but not limited to the following categories,
26 except where the aid is for the purpose of obtaining an abortion:
- 27 (a) Hospital care, including drugs, and medical supplies and services during any

- 1 period of actual hospitalization;
- 2 (b) Nursing-home care, including medical supplies and services, and drugs during
3 confinement therein on prescription of a physician, dentist, or podiatrist;
- 4 (c) Drugs, nursing care, medical supplies, and services during the time when a
5 recipient is not in a hospital but is under treatment and on the prescription of a
6 physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall
7 include products for the treatment of inborn errors of metabolism or genetic,
8 gastrointestinal, and food allergic conditions, consisting of therapeutic food,
9 formulas, supplements, amino acid-based elemental formula, or low-protein
10 modified food products that are medically indicated for therapeutic treatment
11 and are administered under the direction of a physician, and include but are
12 not limited to the following conditions:
- 13 1. Phenylketonuria;
 - 14 2. Hyperphenylalaninemia;
 - 15 3. Tyrosinemia (types I, II, and III);
 - 16 4. Maple syrup urine disease;
 - 17 5. A-ketoacid dehydrogenase deficiency;
 - 18 6. Isovaleryl-CoA dehydrogenase deficiency;
 - 19 7. 3-methylcrotonyl-CoA carboxylase deficiency;
 - 20 8. 3-methylglutaconyl-CoA hydratase deficiency;
 - 21 9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase
22 deficiency);
 - 23 10. B-ketothiolase deficiency;
 - 24 11. Homocystinuria;
 - 25 12. Glutaric aciduria (types I and II);
 - 26 13. Lysinuric protein intolerance;
 - 27 14. Non-ketotic hyperglycinemia;

- 1 15. Propionic acidemia;
- 2 16. Gyrate atrophy;
- 3 17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
- 4 18. Carbamoyl phosphate synthetase deficiency;
- 5 19. Ornithine carbamoyl transferase deficiency;
- 6 20. Citrullinemia;
- 7 21. Arginosuccinic aciduria;
- 8 22. Methylmalonic acidemia;
- 9 23. Argininemia;
- 10 24. Food protein allergies;
- 11 25. Food protein-induced enterocolitis syndrome;
- 12 26. Eosinophilic disorders; and
- 13 27. Short bowel syndrome;
- 14 (d) Physician, podiatric, and dental services. *At a minimum, dental services for*
15 *all age groups shall include relief of pain and infections, restoration of*
16 *teeth, and maintenance of dental health. Dental services shall not be limited*
17 *to emergency services;*
- 18 (e) Optometric services for all age groups shall be limited to prescription services,
19 services to frames and lenses, and diagnostic services provided by an
20 optometrist, to the extent the optometrist is licensed to perform the services
21 and to the extent the services are covered in the ophthalmologist portion of the
22 physician's program. [~~Eyeglasses shall be provided only to children under age~~
23 ~~twenty-one (21)];~~
- 24 (f) Drugs on the prescription of a physician used to prevent the rejection of
25 transplanted organs if the patient is indigent; and
- 26 (g) Nonprofit neighborhood health organizations or clinics where some or all of
27 the medical services are provided by licensed registered nurses or by advanced

1 medical students presently enrolled in a medical school accredited by the
2 Association of American Medical Colleges and where the students or licensed
3 registered nurses are under the direct supervision of a licensed physician who
4 rotates his services in this supervisory capacity between two (2) or more of the
5 nonprofit neighborhood health organizations or clinics specified in this
6 paragraph.

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

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

19 (b) The cost of motor vehicles, including vans or trucks, used for facility business
20 shall be allowed up to fifteen thousand dollars (\$15,000) per facility, adjusted
21 annually for inflation according to the increase in the consumer price index-u
22 for the most recent twelve (12) month period, as determined by the United
23 States Department of Labor. Medically equipped motor vehicles, vans, or
24 trucks shall be exempt from the fifteen thousand dollar (\$15,000) limitation.
25 Costs exceeding this limit shall not be reimbursable and shall be borne by the
26 facility. Costs for additional motor vehicles, not to exceed a total of three (3)
27 per facility, may be approved by the Cabinet for Health and Family Services if

1 the facility demonstrates that each additional vehicle is necessary for the
2 operation of the facility as required by regulations of the cabinet;

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

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

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

21 (f) Payments made to related organizations supplying the facility with goods or
22 services shall be limited to the actual cost of the goods or services to the
23 related organization, unless it can be demonstrated that no relationship
24 between the facility and the supplier exists. A relationship shall be considered
25 to exist when an individual, including brothers, sisters, father, mother, aunts,
26 uncles, and in-laws, possesses a total of five percent (5%) or more of
27 ownership equity in the facility and the supplying business. An exception to

1 the relationship shall exist if fifty-one percent (51%) or more of the supplier's
2 business activity of the type carried on with the facility is transacted with
3 persons and organizations other than the facility and its related organizations.

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

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

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

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

25 (7) To the extent permitted by federal law, no medical assistance recipient shall be
26 recertified as qualifying for a level of long-term care below the recipient's current
27 level, unless the recertification includes a physical examination conducted by a

1 physician licensed pursuant to KRS Chapter 311 or by an advanced practice
2 registered nurse licensed pursuant to KRS Chapter 314 and acting under the
3 physician's supervision.

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

9 (9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to
10 recipients of medical assistance under Title XIX of the Social Security Act on July
11 15, 1986, shall deny admission of a person to a bed certified for reimbursement
12 under the provisions of the Medical Assistance Program solely on the basis of the
13 person's paying status as a Medicaid recipient. No person shall be removed or
14 discharged from any facility solely because they became eligible for participation in
15 the Medical Assistance Program, unless the facility can demonstrate the resident or
16 the resident's responsible party was fully notified in writing that the resident was
17 being admitted to a bed not certified for Medicaid reimbursement. No facility may
18 decertify a bed occupied by a Medicaid recipient or may decertify a bed that is
19 occupied by a resident who has made application for medical assistance.

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

25 (11) The Cabinet for Health and Family Services shall make payments under the Medical
26 Assistance program for services which are within the lawful scope of practice of a
27 chiropractor licensed pursuant to KRS Chapter 312, to the extent the Medical

1 Assistance Program pays for the same services provided by a physician.

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

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

24 (c) Within forty-five (45) days of receipt of a correct and complete application for
25 credentialing by a behavioral health provider providing substance use disorder
26 services, a Medicaid managed care organization shall complete its contracting
27 and credentialing process, unless the Medicaid managed care organization

1 notifies the provider that additional time is needed to render a decision. If
2 additional time is needed, the Medicaid managed care organization shall not
3 take any longer than ninety (90) days from receipt of the credentialing
4 application to deny or approve and contract with the provider.

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

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

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