AN ACT relating to addiction treatment.

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

➔Section 1. 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, ***an opioid antagonist,*** 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 2. 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 January 1, 2022,]~~An insurer ***of a health benefit plan*** 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, ***an opioid antagonist,*** 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. Section 2 of this Act shall apply to health benefit plans issued or renewed on or after January 1, 2025.

➔Section 4. If the Cabinet for Health and Family Services determines that a waiver or other authorization from a federal agency is necessary to implement Section 1 of this Act for any reason, including the loss of federal funds, the cabinet shall, within 90 days of the effective date of this section, request the waiver or other authorization, and may only delay implementation of those provisions for which a waiver or authorization was deemed necessary until the waiver or authorization is granted.

➔Section 5. Sections 2 and 3 of this Act take effect on January 1, 2025.