AN ACT relating to mental health coverage and declaring an emergency.

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

➔Section 1. KRS 304.17A-660 is amended to read as follows:

As used in KRS 304.17A-660 to 304.17A-669, unless the context requires otherwise:

(1) "Classification of benefits" means the classification of benefits set forth in 45 C.F.R. sec. 146.136(c)(2)(ii)(A);

(2) "Mental health condition" means any condition or disorder that***:***

(a) Involves mental illness or substance use disorder as defined in KRS 222.005***;*** and~~[that]~~

(b) 1. Falls under any of the diagnostic categories listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders***;*** or~~[that]~~

2. Is listed in the mental disorders section of the most recent version of the International Classification of Disease;

(3) ***"Health professional" means any health professional, including but not limited to a health care provider, that is licensed or otherwise authorized to practice in Kentucky;***

(4) "Nonquantitative treatment limitation" means any limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment;

(5)~~[(4)]~~ "Terms or conditions" includes day or visit limits, episodes of care, any lifetime or annual payment limits, deductibles, copayments, prescription coverage, coinsurance, out-of-pocket limits, and any other cost-sharing requirements; and

(6)~~[(5)]~~ "Treatment of a mental health condition" includes but is not limited to any necessary outpatient, inpatient, residential, partial hospitalization, day treatment, emergency detoxification, or crisis stabilization services.

➔Section 2. KRS 304.17A-661 is amended to read as follows:

(1) Notwithstanding any other provision of law:

(a) 1. A health benefit plan~~[issued or renewed on or after January 1, 2022,]~~ that provides coverage for treatment of a mental health condition shall provide coverage of any treatment of a mental health condition under terms or conditions that are no more restrictive than the terms or conditions provided for treatment of a physical health condition.

2. Expenses for mental health and physical health conditions shall be combined for purposes of meeting deductible and out-of-pocket limits required under a health benefit plan.

3. A health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all ***physical*** health or mental health conditions may provide coverage for treatment of mental health conditions through a managed care organization;

(b) With respect to mental health condition benefits in any classification of benefits, a health benefit plan required to comply with paragraph (a) of this subsection shall not impose:

1. A nonquantitative treatment limitation that does not apply to medical and surgical benefits in the same classification; and

2. Medical necessity criteria or a nonquantitative treatment limitation unless, under the terms of the plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the criteria or limitation to mental health condition benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the criteria or limitation to medical and surgical benefits in the same classification; and

(c) Paragraph (b) of this subsection shall be construed to require, at a minimum,

compliance with the requirements for nonquantitative treatment limitations set forth in the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. sec. 300gg-26, as amended, and any related federal regulations, as amended, including but not limited to 45 C.F.R. secs. 146.136, 147.160, and 156.115(a)(3).

(2) (a) An insurer that issues or renews a health benefit plan that is subject to the provisions of this section shall submit an annual report~~[to the commissioner]~~ on or before April 1 of each year~~[following January 1, 2022,]~~ that contains the following:

1. A description of the process used to develop or select the medical necessity criteria for both mental health condition benefits and medical and surgical benefits;
2. Identification of all nonquantitative treatment limitations applicable to benefits and services covered under the plan that are applied to both mental health condition benefits and medical and surgical benefits within each classification of benefits;
3. The results of an analysis that demonstrates compliance with subsection (1)(b) and (c) of this section for the medical necessity criteria described in subparagraph 1. of this paragraph and for each nonquantitative treatment limitation identified in subparagraph 2. of this paragraph, as written and in operation. At a minimum, the results of the analysis shall:
   a. Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;
   b. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

c. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies:

i. Used to design each nonquantitative treatment limitation, as written, and the as-written processes and strategies used to apply the nonquantitative treatment limitation to mental health condition benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as-written processes and strategies used to apply the nonquantitative treatment limitation to medical and surgical benefits; and

ii. Used to apply each nonquantitative treatment limitation, in operation, for mental health condition benefits are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

d. Disclose the specific findings and conclusions reached by the insurer that the results of the analyses performed under this subparagraph indicate that the insurer is in compliance with subsection (1)(b) and (c) of this section; and

4. Any additional information that may be prescribed by the commissioner for use in determining compliance with the requirements of this section.

(b) ***Each***~~[The]~~ annual report shall be***:***

1. Submitted ***by the insurer,*** in a manner and format prescribed by the commissioner through administrative regulation***, to the:***

a. Commissioner; and

b. Legislative Research Commission for referral on or before June 1 of each year to the Interim Joint Committees on Health Services and Banking and Insurance and any other appropriate committees; and

2. Published for public distribution by the commissioner on the department's website.

(3) ***(a) Upon request of the commissioner or the Attorney General, an insurer shall have an independent audit conducted by a qualified person, firm, company, or other entity to evaluate the insurer's compliance with this section.***

(b) Upon receipt of an audit completed pursuant to this subsection, an insurer shall promptly submit the report of the auditor to the commissioner and the Attorney General.

(4) (a) The commissioner shall establish and operate a hotline that allows health professionals and insureds to submit complaints regarding any violation of this section in real time.

(b) 1. An insurer shall not directly or indirectly retaliate against a health professional for submitting a complaint regarding the insurer's compliance with this section.

2. As used in subparagraph 1. of this paragraph, "retaliate" includes but is not limited to retaliation through network participation, credentialing, reimbursement, or utilization review.

(5) (a) A willful violation of this section shall constitute an act of discrimination and shall be an unfair trade practice under this chapter.

(b) The remedies provided under Subtitle 12 of this chapter shall apply to conduct in violation of this section.

(6) (a) Subject to paragraph (c) of this subsection, the Attorney General may enforce this section by bringing an action in the name of the

Commonwealth or on behalf of persons residing in the Commonwealth against any person the Attorney General believes has violated, is violating, or is likely to violate this section.

(b) The Attorney General:

1. May demand, and require the production of, any information, documentary material, or evidence from any person the Attorney General believes may have violated, may be violating, or may be likely to violate this section; and

2. Shall have all of the powers and duties provided to the Attorney General under KRS Chapter 15 to investigate and prosecute any violation or likely violation of this section.

(c) 1. Prior to bringing an action under paragraph (a) of this subsection, the Attorney General shall provide each person thirty (30) days written notice of the specific provision or provisions of this section that the Attorney General believes the person has violated, is violating, or is likely to violate.

2. Except as provided in subparagraph 3. of this paragraph, the Attorney General shall not bring an action under paragraph (a) of this subsection against a person if, within thirty (30) days of the date of the notice provided under subparagraph 1. of this paragraph, the person:

a. Cures the noticed violation or violations or likely violation or violations; and

b. Provides the Attorney General with an express written statement that:

i. Any noticed violation or violations have been cured and any noticed likely violation or violations will not occur; and

ii. No further violation or violations, including any likely

violation or violations, of this section by the person will occur.

3. The Attorney General may bring an action under paragraph (a) of this subsection against any person alleged to be in:

a. Violation, or likely violation, of this section following the cure period provided to the person under this paragraph; or

b. Breach of an express written statement submitted by the person to the Attorney General under subparagraph 2.b. of this paragraph.

(d) In any action brought under paragraph (a) of this subsection, the Attorney General may:

1. Obtain:

a. A declaratory judgment that one (1) or more alleged acts or practices by a person or persons violate this section;

b. An injunction against any person that has violated, is violating, or is likely to violate this section; and

c. Any other appropriate orders of the court to compel compliance with this section; and

2. Recover:

a. Actual damages, which shall be paid to the injured person or persons;

b. Any of the civil penalties set forth in KRS 367.990 for a violation of KRS Chapter 367 for each violation and likely violation of this section that occurs after the cure period provided under paragraph (c) of this subsection;

c. Reasonable expenses incurred in investigating and preparing the case;

d. Court costs;

e. Attorney's fees; and

f. Any other relief ordered by the court.

(7) (a) Subject to paragraph (c) of this subsection, any person, including a health professional, directly injured by a violation or likely violation of this section may bring a private cause of action against the person or persons alleged to have committed the violation or likely violation.

(b) An action brought under paragraph (a) of this subsection may be filed in the:

1. Circuit Court of the county in which the injured person resides or conducts business; or

2. Franklin Circuit Court.

(c) Prior to bringing an action under paragraph (a) of this subsection, an injured person shall make reasonable efforts to provide to each person alleged to be in violation or likely violation of this section notice:

1. Of the person's alleged violation and likely violation of this section; and

2. That failure to cure any alleged violation or likely violation of this section within fourteen (14) days of the date of the notice may result in a civil action being filed against the person in a court of competent jurisdiction.

(d) In any action brought under paragraph (a) of this subsection, the plaintiff may:

1. Obtain:

a. A declaratory judgment that one (1) or more alleged acts or practices by a person or persons violate this section;

b. An injunction against any person that has violated, is violating,

or is likely to violate this section; and

c. Any other appropriate orders of the court to compel compliance with this section; and

2. Recover necessary costs, expenses, and reasonable attorney's fees.

(8) Each occurrence of any of the following shall constitute a separate violation of, and direct injury under, this section that is subject to the remedies and penalties available under this section:

(a) A person fails to comply with any requirement of this section;

(b) The denial, delay in approval, or underpayment of a claim under a health benefit plan as a result of a violation under paragraph (a) of this subsection;

(c) An insured seeks but is unable to obtain mental health condition benefits under a health benefit plan as a result of a violation under paragraph (a) of this subsection; and

(d) A health professional attempts but is unable to provide medically necessary mental health condition benefits under a health benefit plan as a result of a violation under paragraph (a) of this subsection.

(9) (a) The remedies and penalties set forth in this section shall be cumulative.

(b) This section shall not be construed to limit or restrict the powers, duties, remedies, or penalties available to the commissioner, the Attorney General, the Commonwealth, or any other person under any other statutory or common law.

(c) An action taken pursuant to this section, or order of a court to enforce an action taken pursuant to this section, shall not in any way relieve or absolve any affected person from any other liability, penalty, or forfeiture under law.

(10) The Attorney General may promulgate administrative regulations in accordance

with KRS Chapter 13A that are necessary to effectuate, or as an aid to the effectuation of, the proper enforcement of this section.

(11) This section shall not be construed to require a health professional to act inconsistent with federal Medicaid, Medicare, or rural health clinic requirements.

➔SECTION 3. A NEW SECTION OF KRS 304.17A-660 TO 304.17A-669 IS CREATED TO READ AS FOLLOWS:

An insurer offering a health benefit plan shall:

(1) Not use review criteria for determining the medical necessity and appropriateness of claims submitted under a health benefit plan for the diagnosis or treatment of a mental health condition unless the review criteria is:

(a) Clinically specified; and

(b) 1. Consistent with generally accepted standards of care.

2. As used in subparagraph 1. of this paragraph, "generally accepted standards of care" includes standards of care established by the American Society of Addiction Medicine, if applicable;

(2) Make the insurer's review criteria for determining the medical necessity and appropriateness of claims submitted under a health benefit plan for the diagnosis or treatment of a mental health condition publicly available on its website; and

(3) Comply with KRS 304.17A-600 to 304.17A-633 with respect to any claim submitted under a health benefit plan by a health professional for the diagnosis or treatment of a mental health condition, except for purposes of this section:

(a) An insurer shall provide an internal appeal decision to the covered person, authorized person, and provider within:

1. Except as provided in paragraph (b) of this subsection, five (5) calendar days, but in no event later than seven (7) calendar days, after receipt of a request for an internal appeal; or

2. a. Twenty-four (24) hours, but in no event later than forty-eight

(48) hours after receipt of a request for an expedited internal appeal.

b. For purposes of this subparagraph, an expedited internal appeal is deemed necessary when, in the opinion of the treating professional, the treatment is:

i. Ongoing; or

ii. Clinically time sensitive;

(b) For an external review other than an expedited external review, an independent review entity shall provide an external review decision to the covered person, treating professional, insurer, and the department within seven (7) calendar days, but in no event later than fourteen (14) calendar days, from the receipt of all information required from the insurer; and

(c) The department shall provide a decision concerning an appeal of a coverage denial within seven (7) calendar days, but in no event later than fourteen (14) calendar days, from the receipt of all information required from the insurer.

➔Section 4. KRS 304.17A-617 is amended to read as follows:

(1) (a) Every insurer shall have an internal appeal process to be utilized by the insurer or its designee, consistent with this section and KRS 304.17A-619 and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g).

(b) An insurer shall disclose the availability of the internal process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial which meets the requirements in KRS 304.17A-607(1)(j).

(c) For purposes of this section, "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.

(d) Where a coverage denial is involved, in addition to stating the reason for the

coverage denial, the required notice shall contain instructions for filing a request for internal appeal.

(2) The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person.

(3) The internal appeals process shall include adequate and reasonable procedures for review and resolution of appeals concerning adverse determinations made under utilization review and of coverage denials, including procedures for reviewing appeals from covered persons whose medical conditions require expedited review. At a minimum, these procedures shall include the following:

(a) Except as provided in KRS 304.17A-163 ***and Section 3 of this Act***:

1. Insurers or their designees shall provide decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal appeal; and

2. Insurers or their designees shall render a decision not later than three (3) business days after receipt of the request for an expedited appeal of either an adverse determination or a coverage denial. An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

a. Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of a bodily organ or part;

(b) Internal appeal of an adverse determination shall only be conducted by a

licensed physician who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board-eligible or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;

(c) Those portions of the medical record that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers given the opportunity to present additional information; and

(d) In addition to any previous notice required under KRS 304.17A-607(1)(j), and to facilitate expeditious handling of a request for external review of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, or device for a covered person shall provide the covered person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that shall include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
2. The state of licensure and the title of the person making the decision, except that an internal appeal determination letter provided to a provider acting on behalf of the covered person shall also include the medical license number of the person making the decision;
3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
4. Instructions for initiating an external review of an adverse determination, or filing a request for review with the department if a

coverage denial is upheld by the insurer on internal appeal.

(4) (a) ***Subject to Section 3 of this Act,*** the department shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers.

(b) For purposes of this subsection, "coverage denials" shall not include an adverse determination as defined in KRS 304.17A-600 or subsequent denials arising from an adverse determination.

(c) On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the department shall notify the insurer which issued the denial of the request for review and shall call for the insurer to respond to the department regarding the request for review within ten (10) business days of receipt of notice to the insurer.

(d) Within ten (10) business days of receiving the notice of the request for review from the department, the insurer shall provide to the department the following information:

1. Confirmation as to whether the person who received or sought the health service for which coverage was denied was a covered person under a health benefit plan issued by the insurer on the date the service was sought or denied;

2. Confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's appeal process under this section; and

3. The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available.

(e) In addition to the information described in paragraph (d) of this subsection, the insurer and the covered person, authorized person, or provider shall

provide to the department any information requested by the department that is germane to its review.

(f) 1. On the receipt of the information described in paragraphs (d) and (e) of this subsection, unless the department is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of the covered person's health benefit plan.

2. If the department determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, or afford the covered person an opportunity for external review under KRS 304.17A-621, 304.17A-623, and 304.17A-625, where the conditions precedent to the review are present.

3. If the department notifies the insurer that the treatment, service, drug, or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review.

(g) An insurer shall be required to cover the treatment, service, drug, or device that was denied or provide notification of the right to external review in accordance with paragraph (f) of this subsection whether the covered person has disenrolled or remains enrolled with the insurer.

(h) If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was denied for a period not to exceed thirty (30) days or provide the covered person the opportunity for external review.

➔Section 5. KRS 304.17A-623 is amended to read as follows:

(1) (a) Every insurer shall have an external review process to be utilized by the insurer or its designee, consistent with this section and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g).

(b) An insurer, its designee, or agent shall disclose the availability of the external review process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial as set forth in KRS 304.17A-607(1)(j) and in the denial letter required in KRS 304.17A-617(1) and (3)(d).

(c) For purposes of this section, "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.

(2) A covered person, an authorized person, or a provider acting on behalf of and with the consent of the covered person, may request an external review of an adverse determination rendered by an insurer, its designee, or agent.

(3) Except as provided in KRS 304.17A-163, the insurer shall provide for an external review of an adverse determination if the following criteria are met:

(a) The insurer, its designee, or agent has rendered an adverse determination;

(b) The covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2). The insurer and the covered person may, however, jointly agree to waive the internal appeal requirement;

(c) The covered person was enrolled in the health benefit plan on the date of service or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested; and

(d) The entire course of treatment or service will cost the covered person at least one hundred dollars ($100) if the covered person had no insurance.

(4) The covered person, an authorized person, or a provider with consent of the covered person shall submit a request for external review to the insurer within sixty (60) days, except as set forth in KRS 304.17A-619(1), of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process. As part of the request, the covered person shall provide to the insurer or its designee written consent authorizing the independent review entity to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

(5) The covered person shall be assessed a one (1) time filing fee of twenty-five dollars ($25) to be paid to the independent review entity and which may be waived if the independent review entity determines that the fee creates a financial hardship on the covered person. The fee shall be refunded if the independent review entity finds in favor of the covered person.

(6) A covered person shall not be afforded an external review of an adverse determination if:

(a) The subject of the covered person's adverse determination has previously gone through the external review process and the independent review entity found in favor of the insurer; and

(b) No relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.

(7) The department shall establish a system for each insurer to be assigned an independent review entity for external reviews. The system established by the department shall be prospective and shall require insurers to utilize independent review entities on a rotating basis so that an insurer does not have the same independent review entity for two (2) consecutive external reviews. The department shall contract with no less than two (2) independent review entities.

(8) (a) If a dispute arises between an insurer and a covered person regarding the

covered person's right to an external review, the covered person may file a complaint with the department. Within five (5) days of receipt of the complaint, the department shall render a decision and may direct the insurer to submit the dispute to an independent review entity for an external review if it finds:

1. The dispute involves denial of coverage based on medical necessity or the service being experimental or investigational; and
2. All of the requirements of subsection (3) of this section have been met.

(b) The complaint process established in this section shall be separate and distinct from, and shall in no way limit other grievance or complaint processes available to consumers under other provisions of the KRS or duly promulgated administrative regulations. This complaint process shall not limit, alter, or supplant the mechanisms for appealing coverage denials established in KRS 304.17A-617.

(9) The external review process shall be confidential and shall not be subject to KRS 61.805 to 61.850 and KRS 61.870 to 61.884.

(10) External reviews shall be conducted in an expedited manner by the independent review entity if the covered person is hospitalized, or if, in the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of a bodily organ or part.

(11) Requests for expedited external review, shall be forwarded by the insurer to the independent review entity within twenty-four (24) hours of receipt by the insurer.

(12) For expedited external review, a determination shall be made by the independent

review entity within twenty-four (24) hours from the receipt of all information required from the insurer. An extension of up to twenty-four (24) hours may be allowed if the covered person and the insurer or its designee agree. The insurer or its designee shall provide notice to the independent review entity and to the covered person, by same-day communication, that the adverse determination has been assigned to an independent review entity for expedited review.

(13) ***Except as provided in Section 3 of this Act,*** external reviews which are not expedited shall be conducted by the independent review entity and a determination made within twenty-one (21) calendar days from the receipt of all information required from the insurer. An extension of up to fourteen (14) calendar days may be allowed if the covered person and the insurer are in agreement.

➔Section 6. KRS 205.522 is amended to read as follows:

(1) With respect to the administration and provision of Medicaid benefits pursuant to this chapter, the Department for Medicaid Services, any managed care organization contracted to provide Medicaid benefits pursuant to this chapter, and the state's medical assistance program shall be subject to, and comply with, the following, as applicable:

(a) KRS 304.17A-129;

(b) KRS 304.17A-145;

(c) KRS 304.17A-163;

(d) KRS 304.17A-1631;

(e) KRS 304.17A-167;

(f) KRS 304.17A-235;

(g) KRS 304.17A-257;

(h) KRS 304.17A-259;

(i) KRS 304.17A-263;

(j) KRS 304.17A-264;

(k) KRS 304.17A-515;

(l) KRS 304.17A-580;

(m) KRS 304.17A-600, 304.17A-603, and 304.17A-607;~~[and]~~

(n) KRS 304.17A-740 to 304.17A-743***; and***

(o) Section 2 of this Act.

(2) A managed care organization contracted to provide Medicaid benefits pursuant to this chapter shall comply with the reporting requirements of KRS 304.17A-732.

➔Section 7. Sections 1 to 5 of this Act apply to health benefit plans issued or renewed on or after January 1, 2027.

➔Section 8. If the Cabinet for Health and Family Services or the Department for Medicaid Services determines that a state plan amendment, waiver, or any other form of authorization or approval from any federal agency to implement Section 6 of this Act is necessary to prevent the loss of federal funds or to comply with federal law, the cabinet or department:

(1) Shall, within 90 days after the effective date of this section, request the necessary federal authorization or approval to implement Section 6 of this Act; and

(2) May only delay implementation of the provisions of Section 6 of this Act for which federal authorization or approval was deemed necessary until the federal authorization or approval is granted.

➔Section 9. Sections 6 and 8 of this Act shall constitute the specific authorization required under KRS 205.5372(1).

➔Section 10. The Department for Medicaid Services or the Cabinet for Health and Family Services shall, in accordance with KRS 205.525, provide a copy of any state plan amendment, waiver application, or other request for authorization or approval submitted pursuant to Section 8 of this Act to the Legislative Research Commission for referral to the Interim Joint Committees on Health Services and Appropriations and Revenue and shall provide an update on the status of any application or request submitted

pursuant to Section 8 of this Act at the request of the Legislative Research Commission or any committee thereof.

➔Section 11. Sections 3, 4, and 5 of this Act take effect January 1, 2027.

➔Section 12. Whereas parity in the provision of mental health condition benefits is imperative to the health and well-being of the citizens of the Commonwealth, an emergency is declared to exist, and Sections 1, 2, 6, 7, 8, 9, and 10 of this Act take effect upon its passage and approval by the Governor or upon its otherwise becoming a law.