# GENERAL ASSEMBLY
## COMMONWEALTH OF KENTUCKY

## 2013 REGULAR SESSION

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HOUSE BILL NO. 366

AS ENACTED

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TUESDAY, MARCH 26, 2013

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RECEIVED AND FILED
DATE April 4, 2013
3:16pm

ALISON LUNDERGAN GRIMES
SECRETARY OF STATE
COMMONWEALTH OF KENTUCKY
BY K. Adler

AN ACT relating to physical and health services and declaring an emergency.

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

➔Section 1. KRS 309.325 is amended to read as follows:

As used in KRS 309.325 to 309.339, unless the context requires otherwise:

(1) "Board" means the Kentucky Board of Licensed Diabetes Educators;

(2) "Diabetes education" means a comprehensive collaborative process through which people with or at risk for diabetes gain the knowledge and skills needed to modify behavior and successfully self-manage the disease and its related conditions;

(3) "Licensed diabetes educator" means a health care professional who has met the requirements of KRS 309.335, 309.337, and 309.339 and who focuses on training or educating people with or at risk for diabetes and related conditions to change their behavior to achieve better clinical outcomes and improved health status. The nondiabetes educator health professional and the nonhealth-care professional who provide or support health care services to individuals with diabetes as defined by the American Association of Diabetes Educators, Competencies for Diabetes Educators, shall work under the direction of a qualified diabetes care provider;~~[~~ ~~and]~~

(4) "Practice of diabetes education" means assessing and developing a plan of care for a person with or at risk of diabetes, identifying self-management goals for the person, providing self-management training according to the plan, evaluating the individual's outcome and recording a complete record of the individual's experience and follow-ups;

***(5) "Apprentice diabetes educator" means a person who holds a permit issued by the board to practice diabetes education who meets the requirements of Section 2 of this Act and the corresponding administrative regulations promulgated by the board; and***

***(6) "Master licensed diabetes educator" means a licensed diabetes educator who has***

*successfully completed the credentialing program of the American Association of Diabetes Educators or the National Certification Board for Diabetes Educators as a certified diabetes educator or a board-certified advanced diabetes manager.*

➔SECTION 2. A NEW SECTION OF KRS 309.325 TO 309.339 IS CREATED TO READ AS FOLLOWS:

*(1) An applicant for a permit as an apprentice diabetes educator shall:*

*(a) File a written application on forms provided by the board in order to practice and earn the experience required for a type of license application;*

*(b) Engage in the practice of diabetes education while receiving qualifying experience with a board-approved supervisor who shall assume responsibility for and supervise the apprentice diabetes educator's practice;*

*(c) Not practice diabetes education until a supervisor has been approved by the board;*

*(d) Cease the practice of diabetes education immediately upon the supervisor's inability or unwillingness to act as the supervisor; and*

*(e) Upon gaining the required supervision hours and completing a board-approved diabetes educator course, apply for licensure as a licensed diabetes educator.*

*(2) The board shall promulgate administrative regulations to do the following, including but not limited to:*

*(a) Establish the duties of the apprentice diabetes educator supervisor;*

*(b) Establish fees; and*

*(c) Establish additional requirements for an apprentice diabetes educator permit as the board determines are necessary.*

➔SECTION 3. A NEW SECTION OF KRS 309.325 TO 309.339 IS CREATED TO READ AS FOLLOWS:

*(1) An applicant for licensure as a master licensed diabetes educator shall:*

***(a) File a written application on forms provided by the board; and***

***(b) Provide proof of completion of the credentialing program of the American Association of Diabetes Educators or the National Certification Board for Diabetes Educators as a certified advanced diabetes manager or a certified diabetes educator.***

***(2) The board shall promulgate administrative regulations to do the following, including but not limited to:***

***(a) Establish a fee for licensure; and***

***(b) Establish additional requirements for a master licensed diabetes educator as the board determines are necessary.***

➔Section 4. KRS 309.327 is amended to read as follows:

(1) ***A***~~[No]~~ person shall use the title ***"master licensed diabetes educator,"*** "licensed diabetes educator," ***or "apprentice diabetes educator"*** or hold himself or herself out as a ***"master licensed diabetes educator,"*** "licensed diabetes educator," ***or "apprentice diabetes educator"*** or a title substantially similar, or engage in the practice of diabetes education, display a sign or in any other way advertise or present himself or herself as a person who practices diabetes education ***only if***~~[unless]~~ he or she holds a current, unsuspended and unrevoked license ***or permit*** issued by the board pursuant to KRS 309.325 to 309.339.

(2) Nothing in KRS 309.325 to 309.339 shall apply to persons licensed, certified, or registered under any other provision of the Kentucky Revised Statutes, including but not limited to physicians, nurses, pharmacists, dietitians, and nutritionists or students in accredited training programs in those professions, and nothing in KRS 309.325 to 309.339 shall be construed to limit, interfere with, or restrict the practice, descriptions of services, or manner in which they hold themselves out to the public.

(3) Nothing in KRS 309.325 to 309.339 shall be construed to alter, amend, or interfere

with the practice of those who provide health care services, including but not limited to physicians, nurses, pharmacists, dietitians, and nutritionists.

(4) Nothing in KRS 309.325 to 309.339 shall apply to activities and services of an accredited institution of higher education as part of a program of studies.

➔Section 5. KRS 309.335 is amended to read as follows:

(1) An applicant for licensure as a diabetes educator shall:

(a) File a written application on forms provided by the board;

(b) Provide evidence to the board showing successful completion of one (1) of the following:

1. ***A board-approved course in diabetes education***~~[The American Association of Diabetes Educators' "Core Concepts Course"]~~ with demonstrable experience in the care of people with diabetes under supervision that meets requirements specified in administrative regulations promulgated by the board;

2. The credentialing program of the American Association of Diabetes Educators or the National Certification Board for Diabetes Educators; or

3. An equivalent credentialing program as determined by the board; and

(c) Pay licensing amounts as promulgated by the board through administrative regulation, with the following restrictions:

1. Initial licensing shall not exceed one hundred dollars ($100);

2. Annual renewal shall not exceed one hundred dollars ($100);

3. Biennial renewal shall not exceed two hundred dollars ($200);~~[ and]~~

4. Late renewal shall not exceed one hundred fifty dollars ($150)***; and***

***5. The reinstatement fee shall not exceed two hundred twenty-five dollars ($225)***.

(2) (a) Licenses ***or permits*** shall be renewed annually or biennially if the board requires biennial license renewal by administrative regulation.

(b) Licenses ***or permits*** not renewed within thirty (30) days after the renewal date shall pay a late penalty as promulgated by the board in administrative regulation.

(c) Licenses ***or permits*** not renewed within ninety (90) days of the renewal date shall lapse and may only be reinstated with payment of a ***reinstatement fee***~~[late renewal penalty]~~ and initial licensing amount as promulgated by the board in administrative regulation.

***(d) An apprentice diabetes educator shall not carry a permit for more than five (5) years without becoming licensed.***

(3) Notwithstanding subsections (1) and (2) of this section, prior to July 1, ***2014***~~[2012]~~, a person who the board finds to have successfully achieved a core body of knowledge and skills in the biological and social sciences, communication, counseling, and education, by training or instruction, as well as experience in the care of people with diabetes under supervision that meets the requirements specified in administrative regulations promulgated by the board, may be issued an initial license by the board upon payment of an initial licensing fee, completion of a written application on forms provided by the board, and submission of any other information requested by the board.

***(4) Until May 1, 2014, notwithstanding subsection (1) of this section, individuals who have practiced diabetes education for a minimum of one thousand (1,000) hours per year for the past three (3) years, but are not currently credentialed by the American Association of Diabetes Educators as a board-certified advanced diabetes manager or by the National Certification Board for Diabetes Educators as a certified diabetes educator, may apply to the board for licensure as a diabetes educator by submitting the initial licensure fee and proof of employment, in order to continue to practice diabetes education, as defined by KRS 309.325(2).***

➔Section 6. KRS 211.400 is amended to read as follows:

(1) To the extent possible with available funds, the Cabinet for Health and Family Services shall establish and operate the Kentucky Physicians Care Program to assist low-income uninsured ***and underinsured*** individuals in accessing primary health care services provided by volunteer health care practitioners and pharmaceutical drugs donated by pharmaceutical companies.

(2) The program may access networks of practitioners, pharmacies, and pharmaceutical companies that are maintained by entities that recruit volunteers and donations, such as Health Kentucky, Inc. ***and the Kentucky Free Health Clinic Association***, to locate necessary health care services for eligible applicants.

(3) The program shall:

(a) Operate and maintain a professionally staffed toll-free hotline information and referral service for individuals seeking primary care;

(b) Refer individuals seeking health care services to the Department for Community Based Services or other enrollment sites approved by the cabinet for eligibility determination;

(c) Refer individuals determined to be eligible to available health care service providers; and

(d) Maintain a confidential record of all referrals.

(4) The program may:

(a) Create temporary volunteer advisory committees to provide input on program operations and efficiencies;

(b) Contract with qualified, independent third parties to provide services; and

(c) Apply for federal funds or other grants to operate the program.

➔Section 7. KRS 211.402 is amended to read as follows:

(1) Individuals may apply for primary care services available from the Kentucky Physicians Care Program in their local Department for Community Based Services office or other enrollment sites approved by the cabinet.~~[ An individual shall be~~

~~eligible for services available from the program if he or she meets the following criteria:~~

~~(a) A gross income limit of one hundred percent (100%) of the federal poverty level;~~

~~(b) A resource limit of two thousand dollars ($2,000);~~

~~(c) Is not qualified for government medical assistance programs; and~~

~~(d) Is not covered by a health benefit plan as defined under Subtitle 17A of KRS Chapter 304.~~]

(2) If an individual is determined to be eligible, the department shall refer the individual to the program. An individual shall be eligible for services available under the program for one (1) year and may reapply.

(3) Services that may be available from the program include but are not limited to visits to health care professionals and prescription drugs donated by pharmaceutical companies and filled by retail and hospital pharmacies. Eligibility for the program does not guarantee an individual access to free services not available under the program.

(4) Individuals shall not be charged a fee for services provided under this program.

(5) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A to ***establish eligibility criteria and*** implement the provisions of KRS 211.400 and 211.402.

➔Section 8. KRS 205.560 is amended to read as follows:

(1) The scope of medical care for which the Cabinet for Health and Family Services undertakes to pay shall be designated and limited by regulations promulgated by the cabinet, pursuant to the provisions in this section. Within the limitations of any appropriation therefor, the provision of complete upper and lower dentures to recipients of Medical Assistance Program benefits who have their teeth removed by a dentist resulting in the total absence of teeth shall be a mandatory class in the

scope of medical care. Payment to a dentist of any Medical Assistance Program benefits for complete upper and lower dentures shall only be provided on the condition of a preauthorized agreement between an authorized representative of the Medical Assistance Program and the dentist prior to the removal of the teeth. The selection of another class or other classes of medical care shall be recommended by the council to the secretary for health and family services after taking into consideration, among other things, the amount of federal and state funds available, the most essential needs of recipients, and the meeting of such need on a basis insuring the greatest amount of medical care as defined in KRS 205.510 consonant with the funds available, including but not limited to the following categories, except where the aid is for the purpose of obtaining an abortion:

(a) Hospital care, including drugs, and medical supplies and services during any period of actual hospitalization;

(b) Nursing-home care, including medical supplies and services, and drugs during confinement therein on prescription of a physician, dentist, or podiatrist;

(c) Drugs, nursing care, medical supplies, and services during the time when a recipient is not in a hospital but is under treatment and on the prescription of a physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall include products for the treatment of inborn errors of metabolism or genetic conditions, consisting of therapeutic food, formulas, supplements, or low-protein modified food products that are medically indicated for therapeutic treatment and are administered under the direction of a physician, and include but are not limited to the following conditions:

1. Phenylketonuria;
2. Hyperphenylalaninemia;
3. Tyrosinemia (types I, II, and III);
4. Maple syrup urine disease;

5. A-ketoacid dehydrogenase deficiency;

6. Isovaleryl-CoA dehydrogenase deficiency;

7. 3-methylcrotonyl-CoA carboxylase deficiency;

8. 3-methylglutaconyl-CoA hydratase deficiency;

9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency);

10. B-ketothiolase deficiency;

11. Homocystinuria;

12. Glutaric aciduria (types I and II);

13. Lysinuric protein intolerance;

14. Non-ketotic hyperglycinemia;

15. Propionic acidemia;

16. Gyrate atrophy;

17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;

18. Carbamoyl phosphate synthetase deficiency;

19. Ornithine carbamoyl transferase deficiency;

20. Citrullinemia;

21. Arginosuccinic aciduria;

22. Methylmalonic acidemia; and

23. Argininemia;

(d) Physician, podiatric, and dental services;

(e) Optometric services for all age groups shall be limited to prescription services, services to frames and lenses, and diagnostic services provided by an optometrist, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses shall be provided only to children under age twenty-one (21);

(f) Drugs on the prescription of a physician used to prevent the rejection of transplanted organs if the patient is indigent;

(g) Nonprofit neighborhood health organizations or clinics where some or all of the medical services are provided by licensed registered nurses or by advanced medical students presently enrolled in a medical school accredited by the Association of American Medical Colleges and where the students or licensed registered nurses are under the direct supervision of a licensed physician who rotates his services in this supervisory capacity between two (2) or more of the nonprofit neighborhood health organizations or clinics specified in this paragraph;

(h) Services provided by health-care delivery networks as defined in KRS 216.900;

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

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

(2) Payments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies. It shall be one (1) of the functions of the council to make recommendations to the Cabinet for Health and Family Services with respect to the bases for payment. In determining the rates of reimbursement for long-term-care facilities participating in the Medical Assistance

Program, the Cabinet for Health and Family Services shall, to the extent permitted by federal law, not allow the following items to be considered as a cost to the facility for purposes of reimbursement:

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

(b) The cost of motor vehicles, including vans or trucks, used for facility business shall be allowed up to fifteen thousand dollars ($15,000) per facility, adjusted annually for inflation according to the increase in the consumer price index-u for the most recent twelve (12) month period, as determined by the United States Department of Labor. Medically equipped motor vehicles, vans, or trucks shall be exempt from the fifteen thousand dollar ($15,000) limitation. Costs exceeding this limit shall not be reimbursable and shall be borne by the facility. Costs for additional motor vehicles, not to exceed a total of three (3) per facility, may be approved by the Cabinet for Health and Family Services if the facility demonstrates that each additional vehicle is necessary for the operation of the facility as required by regulations of the cabinet;

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

(d) The cost of contracts, loans, or other payments made by the facility to owners, administrators, or both, unless the payments are for services which would otherwise be necessary to the operation of the facility and the services are required by regulations of the Cabinet for Health and Family Services. Any other payments shall be deemed part of the owner's compensation in

accordance with maximum limits established by regulations of the Cabinet for Health and Family Services. Interest paid to the facility for loans made to a third party may be used to offset allowable interest claimed by the facility;

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

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

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

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

(5) The range of medical care benefit standards provided and the quality and quantity standards and the methods for determining cost formulae for vendor payments within each category of public assistance and other recipients shall be uniform for

the entire state, and shall be designated by regulation promulgated within the limitations established by the Social Security Act and federal regulations. It shall not be necessary that the amount of payments for units of services be uniform for the entire state but amounts may vary from county to county and from city to city, as well as among hospitals, based on the prevailing cost of medical care in each locale and other local economic and geographic conditions, except that insofar as allowed by applicable federal law and regulation, the maximum amounts reimbursable for similar services rendered by physicians within the same specialty of medical practice shall not vary according to the physician's place of residence or place of practice, as long as the place of practice is within the boundaries of the state.

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

(7) To the extent permitted by federal law, no medical assistance recipient shall be recertified as qualifying for a level of long-term care below the recipient's current level, unless the recertification includes a physical examination conducted by a physician licensed pursuant to KRS Chapter 311 or by an advanced practice registered nurse licensed pursuant to KRS Chapter 314 and acting under the physician's supervision.

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

(9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to recipients of medical assistance under Title XIX of the Social Security Act on July 15, 1986, shall deny admission of a person to a bed certified for reimbursement under the provisions of the Medical Assistance Program solely on the basis of the

person's paying status as a Medicaid recipient. No person shall be removed or discharged from any facility solely because they became eligible for participation in the Medical Assistance Program, unless the facility can demonstrate the resident or the resident's responsible party was fully notified in writing that the resident was being admitted to a bed not certified for Medicaid reimbursement. No facility may decertify a bed occupied by a Medicaid recipient or may decertify a bed that is occupied by a resident who has made application for medical assistance.

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

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

(12) The Medical Assistance Program shall use the form and guidelines established pursuant to KRS 304.17A-545(5) for assessing the credentials of those applying for participation in the Medical Assistance Program, including those licensed and regulated under KRS Chapters 311, 312, 314, 315, and 320, any facility required to be licensed pursuant to KRS Chapter 216B, and any other health care practitioner or facility as determined by the Department for Medicaid Services through an administrative regulation promulgated under KRS Chapter 13A. ***For any provider who is credentialed by a Medicaid managed care organization the cabinet shall complete the enrollment and credentialing process and deny, or approve and issue a Medical Assistance Identification Number (MAID) within fifteen (15) business days from the time all necessary completed credentialing forms have***

***been submitted and all outstanding accounts receivable have been satisfied.***

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

➔SECTION 9. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

***(1) As used in this section, "IMPACT Plus" program means the program of community-based behavioral health services provided to an eligible IMPACT Plus recipient through an agreement between the Department for Medicaid Services and the Department for Public Health as the state agency for the federal Title V Maternal and Child Health Block Grant, 42 U.S.C. secs. 701 to 710 or as authorized under subsection (3) of this section.***

***(2) Any Medicaid managed care organization that contracts with the Department for Medicaid Services shall, to the extent possible under the Title V agreement, manage aspects of the IMPACT Plus program for its members, including but not limited to the determination of a child's eligibility for IMPACT Plus services, processing and direct payment of claims, and audits. No state agency shall duplicate any function performed by the Medicaid managed care organizations for the IMPACT Plus program. Appeals of payments shall be submitted for review to the Department for Behavioral Health, Developmental and Intellectual Disabilities.***

***(3) Children eligible for the IMPACT Plus program may continue to receive services, if the family and provider agree, from:***

***(a) An individual IMPACT Plus therapist if the child is relocated outside of the provider's service area; and***

***(b) The same provider if a child is eligible for those services, but no longer***

*eligible for IMPACT Plus services, and the provider meets the participation standards to provide services under the acquired brain injury, the Michelle P. waiver, the supports for community living, or the home and community based waiver programs.*

*(4) IMPACT Plus providers shall bill for all IMPACT Plus services, including case management, under their IMPACT Plus provider identification. IMPACT Plus providers shall not be required to obtain a Medical Assistance Identification Number (MAID). Nothing in this section shall preclude an IMPACT Plus provider from applying for a MAID number, providing they meet all necessary criteria.*

*(5) Medicaid managed care organizations may report documented gaps in IMPACT Plus services or lack of access to IMPACT Plus services to the Department for Behavioral Health, Developmental and Intellectual Disabilities. The Department for Behavioral Health, Developmental and Intellectual Disabilities shall verify or not verify the reported gaps.*

*(6) If the Department for Behavioral Health, Developmental and Intellectual Disabilities verifies gaps in IMPACT Plus services or lack of access to IMPACT Plus services, IMPACT Plus providers may be utilized for additional IMPACT Plus services and additional IMPACT Plus providers may be utilized.*

➔SECTION 10. A NEW SECTION OF KRS 217.005 TO 217.215 IS CREATED TO READ AS FOLLOWS:

*(1) A licensed health-care provider who, acting in good faith, directly or by standing order, prescribes or dispenses the drug naloxone to a patient who, in the judgment of the health-care provider, is capable of administering the drug for an emergency opioid overdose, shall not, as a result of his or her acts or omissions, be subject to disciplinary or other adverse action under KRS Chapter 311, 311A, 314, or 315 or any other professional licensing statute.*

***(2) A prescription for naloxone may include authorization for administration of the drug to the person for whom it is prescribed by a third party if the prescribing instructions indicate the need for the third party upon administering the drug to immediately notify a local public safety answering point of the situation necessitating the administration. A person acting in good faith who administers naloxone as the third party under this section shall be immune from criminal and civil liability for the administration, unless personal injury results from the gross negligence or willful or wanton misconduct of the person administering the drug.***

➔Section 11. KRS 304.17A-139 is amended to read as follows:

(1) A health benefit plan that provides coverage for a family or dependent shall provide coverage of a newly born child of the insured from the moment of birth.

(2) Coverage for a newly born child shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium or fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within thirty-one (31) days after the date of birth in order to have the coverage continue beyond that thirty-one (31) day period.

***(4) (a) For the purposes of this subsection:***

***1. "Milk fortifier" means a commercially prepared human milk fortifier made from concentrated one hundred percent (100%) human milk.***

***2. "One hundred percent (100%) human diet" means the supplementation of a mother's expressed breast milk or donor milk with a milk fortifier.***

***(b) A health benefit plan that provides prescription drug coverage shall provide that coverage for a one hundred percent (100%) human diet, if the one***

*hundred percent (100%) human diet and supplemented milk fortifier products are prescribed for the prevention of Necrotizing Enterocolitis and associated comorbidities, and are administered under the direction of a physician. Coverage under this subsection may be subject to a cap of fifteen thousand dollars ($15,000) per infant, for each plan year, subject to annual inflation adjustments.*

*(5) The requirements of this section shall apply to all health benefit plans delivered or issued for delivery on or after the effective date of this Act.*

➔SECTION 12. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

*As used in Sections 12 to 15 of this Act, unless the context requires otherwise:*

*(1) "Cabinet" means the Cabinet for Health and Family Services;*

*(2) "Commissioner" means the commissioner of the Department for Public Health;*

*(3) "Department" means the Department for Public Health; and*

*(4) "Secretary" means the secretary of the Cabinet for Health and Family Services.*

➔SECTION 13. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

*(1) (a) The secretary shall appoint the Perinatal Advisory Committee to make recommendations for the improvement of the following statewide health status indicators that relate to pregnancy and perinatal care:*

*1. Infant mortality;*

*2. Preterm birth;*

*3. Substance abuse during pregnancy;*

*4. Neonatal withdrawal syndrome, also called Neonatal Abstinence Syndrome (NAS); and*

*5. Maternal mortality.*

*(b) The committee may make recommendations on evidence-based guidelines*

*and programs to improve the outcomes of pregnancies, including ways to improve coordination of existing programs operated by the cabinet and private organizations.*

*(2) The advisory committee shall be attached to the cabinet for administrative purposes and be composed of the following members:*

*(a) The director of the Division of Maternal and Child Health, Department for Public Health, who shall serve as chair of the advisory committee;*

*(b) The director of the Division of Maternal-Fetal Medicine, University of Kentucky College of Medicine;*

*(c) The director of the Division of Maternal-Fetal Medicine, University of Louisville School of Medicine;*

*(d) The director of a maternal-fetal medicine program from a pediatric teaching hospital with a Level III NICU that has a minimum of thirty (30) beds, to be selected by the secretary;*

*(e) The director of the Division of Neonatology, University of Kentucky College of Medicine;*

*(f) The director of the Division of Neonatology, University of Louisville School of Medicine;*

*(g) One (1) practicing obstetrician from rural practice in a hospital with a Level I nursery, to be selected by the secretary;*

*(h) One (1) practicing obstetrician from rural practice in a hospital with a Level II neonatal intensive care unit (NICU), to be selected by the secretary;*

*(i) One (1) practicing pediatrician from rural practice in a hospital with a Level I nursery, to be selected by the secretary;*

*(j) One (1) practicing pediatrician or one (1) practicing neonatologist from rural practice in a hospital with a Level II NICU, to be selected by the secretary;*

*(k) One (1) practicing pediatrician or one (1) practicing neonatologist from a non-university urban practice hospital with a Level II NICU, to be selected by the secretary;*

*(l) One (1) practicing pediatrician or one (1) practicing neonatologist from a pediatric teaching hospital with a Level III NICU that has a minimum of thirty (30) beds, to be selected by the secretary;*

*(m) The president of the Kentucky Perinatal Association or designee;*

*(n) The president of the Kentucky Academy of Family Practice or designee;*

*(o) The president of the Kentucky Chapter of the American Academy of Pediatrics or designee;*

*(p) The president of the Kentucky Section of the American College of Obstetricians and Gynecologists or designee;*

*(q) The president of the Kentucky Chapter of the Association of Women's Health, Obstetric, and Neonatal Nurses or designee;*

*(r) The chair of the Kentucky Medical Association's Committee on Maternal and Neonatal Health or designee;*

*(s) The chair of the Kentucky Medical Association's Committee on Maternal Mortality or designee;*

*(t) One (1) board-certified pediatric surgeon, to be selected by the secretary;*

*(u) One (1) board-certified pediatrician specializing in medical genetics, to be selected by the secretary;*

*(v) One (1) perinatal social worker, to be selected by the secretary; and*

*(w) One (1) representative from a non-university hospital with a Level II or a Level III NICU, selected by the secretary.*

*(3) Other subject matter experts may be represented as members of the advisory committee at the discretion of the secretary.*

*(4) The advisory committee shall meet at least quarterly and shall hold its first*

*meeting no later than thirty (30) days after the effective date of this Act.*

*(5) The advisory committee shall submit an annual report of its activities and recommendations to the secretary and the commissioner.*

➔SECTION 14. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

*All cases of Neonatal Abstinence Syndrome (NAS) diagnosed among Kentucky resident births shall be reported to the Kentucky Department for Public Health by the facility where NAS is diagnosed. The report shall be made at the time of NAS diagnosis pursuant to guidance issued by the department.*

➔SECTION 15. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

*(1) Notwithstanding any other law to the contrary, all information reported or furnished to the Kentucky Department for Public Health pursuant to Sections 12 to 15 of this Act shall be privileged and confidential, shall not be considered a public record under KRS 61.870 to 61.884, and shall not be discussed at any meeting as defined in KRS 61.805, unless conducted in a closed session in accordance with KRS 61.815.*

*(2) Information reported in compliance with Sections 12 to 15 of this Act shall not be disclosed by any person or entity, and shall not be subject to subpoena, court order, or discovery, or admissible as evidence in any civil or administrative proceeding in the Commonwealth.*

*(3) For purposes of this section, "information" shall be liberally construed to include reports; statements; interviews; memoranda; data, whether kept individually or aggregated; or summaries of same.*

*(4) Nothing within this section is intended to limit the Kentucky Department for Public Health's internal use of such information to fulfill the express purposes of Sections 12 to 15 of this Act.*

➔SECTION 16. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

*(1) As used in this section and KRS 211.690:*

*(a) "Home visitation" means a service delivery strategy with voluntary participation by eligible families that is carried out in the homes of at-risk parents during the prenatal period and until the child's third birthday that provides face-to-face visits by nurses, social workers, and other early childhood professionals or trained and supervised paraprofessionals to improve maternal, infant, and child health and well-being, including:*

*1. Reducing preterm births;*

*2. Promoting positive parenting practices;*

*3. Improving school readiness;*

*4. Enhancing the social, emotional, and cognitive development of children;*

*5. Reducing child abuse and neglect;*

*6. Improving the health of the family; and*

*7. Empowering families to be self-sufficient;*

*(b) "Home visitation program" means the voluntary statewide home visiting program established by KRS 211.690 or a program implementing a research-based model or a promising model that includes voluntary home visitation as a primary service delivery strategy that may supplement but shall not duplicate any existing program that provides assistance to parents of young children and that does not include:*

*1. Programs with few or infrequent home visits;*

*2. Home visits based on professional judgment or medical referrals that are infrequent and supplemental to a treatment plan;*

*3. Programs in which home visiting is supplemental to other services,*

*such as child protective services;*

*4. In-home services delivered through provisions of an individualized family service plan or individualized education program under the federal Individuals with Disabilities Education Act, Part B or C; or*

*5. Programs with goals related to direct intervention of domestic violence or substance abuse;*

*(c) "Research-based model" means a home visitation model based on a clear, consistent program model that:*

*1. Is research-based, grounded in relevant empirically based knowledge, linked to program determined outcomes, has comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement, and has demonstrated significant, sustained positive outcomes;*

*2. Employs highly trained and competent professionals or paraprofessionals who are provided close supervision and continual professional development and training relevant to the specific model being delivered;*

*3. Demonstrates strong linkages to other community-based services; and*

*4. Is operated within an organization to ensure program fidelity and meets the outlined objectives and criteria for the model design; and*

*(d) "Promising model" means a home visitation model that has ongoing research, is modeled after programs with proven standards and outcomes, and has demonstrated its effectiveness or is actively incorporating model evaluation protocols designed to measure its efficacy.*

*(2) Beginning fiscal year 2014, an agency receiving state funds for the purpose of the delivery of home visitation services shall:*

*(a) Meet the definition of home visitation program in this section;*

***(b) Demonstrate to the Department for Public Health that it is part of a coordinated system of care for promoting health and well-being for at-risk parents during the prenatal period and until the child's third birthday; and***

***(c) Report data to the statewide home visiting data system managed by the Department for Public Health in a uniform format prescribed by the department assuring common data elements, relevant home visiting data, and information to monitor program effectiveness, including program outcomes, numbers of families served, and other relevant data as determined by the department.***

➔SECTION 17. A NEW SECTION OF KRS CHAPTER 14 IS CREATED TO READ AS FOLLOWS:

***(1) As funds are available, the Secretary of State, or designee, may promulgate administrative regulations to expand the address protection program to allow an applicant or specified guardians to apply to have a substitute address designated to serve as the address of the participant. Any program created under this section shall:***

***(a) Collaborate with the Kentucky Commission on Women;***

***(b) Establish criteria to prohibit certain individuals, including any individual required to register as a sex offender, from participation in the program;***

***(c) Allow a participant to request that state and local agencies use the substitute address as the address of the participant, but agencies may show that they have a bona fide statutory or administrative requirement for the actual address;***

***(d) Be open to individuals that are victims of domestic violence and abuse, stalking, any victim of an offense or an attempt to commit an offense defined in KRS Chapter 510, KRS 530.020, KRS 530.064(1)(a), KRS 531.310, or KRS 531.320, or any victim of a similar federal offense or a***

***similar offense from another state or territory;***

***(e) Allow an applicant to submit evidence, including a sworn statement, to show that he or she is a victim of a qualifying offense.***

***(2) Participation in any program established under this section shall not affect custody or visitation orders in effect prior to or established during program participation, nor shall it constitute evidence of any offense and shall not be considered for purposes of making an order allocating parental responsibilities or parenting time.***

***(3) No actionable duty nor any right of action shall accrue against the state, any entity operating an address protection program for the state, an individual operating in his or her professional capacity on behalf of the confidential address protection program established in this section, or an employee of the state or municipality in the event of negligent acts that result in the disclosure of a program participant's actual address.***

➔Section 18. Section 4 of this Act takes effect July 1, 2014.

➔Section 19. Whereas it is in the interest of the public welfare, an emergency is declared to exist, and Section 8 of this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming a law.

Speaker-House of Representatives

President of Senate

Attest: Jean C. Burgin
Chief Clerk of House of Representatives

Approved
Governor

Date 4-4-13