

CHAPTER 143**(HB 444)**

AN ACT relating to health facilities and services.

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

➔Section 1. KRS 216.2927 is amended to read as follows:

- (1) The following types of data shall be deemed as relating to personal privacy and, except by court order, shall not be published or otherwise released by the cabinet or its staff and shall not be subject to inspection under KRS 61.870 to 61.884:
 - (a) Any data, summary of data, correspondence, or notes that identify or could be used to identify any individual patient or member of the general public, unless the identified individual gives written permission to release the data or correspondence;
 - (b) Any correspondence or related notes from or to any employee or employees of a provider if the correspondence or notes identify or could be used to identify any individual employee of a provider, unless the corresponding persons grant permission to release the correspondence; and
 - (c) Data considered by the cabinet to be incomplete, preliminary, substantially in error, or not representative, the release of which could produce misleading information.
- (2) Health-care providers submitting required data to the cabinet shall not be required to obtain individual permission to release the data, except as specified in subsection (1) of this section, and, if submission of the data to the cabinet complies with pertinent administrative regulations promulgated pursuant to KRS Chapter 13A, shall not be deemed as having violated any statute or administrative regulation protecting individual privacy.
- (3)
 - (a) No less than sixty (60) days after the annual report or reports are published and except as otherwise provided, the cabinet shall make all aggregate data which does not allow disclosure of the identity of any individual patient, and which was obtained for the annual period covered by the reports, available to the public.
 - (b) Persons or organizations requesting use of the data shall agree to abide by a public-use data agreement and by ~~HIPAA~~~~[HIPAA]~~ privacy rules referenced in 45 C.F.R. Part 164. The public-use data agreement shall include, at a minimum, a prohibition against the sale or further release of data, and guidelines for the use and analysis of the data released to the public related to provider quality, outcomes, or charges.
 - ~~[(c) Single copies of the printed data shall be made available to individuals at no cost. The cabinet may impose a fee for providing electronic or multiple printed copies of the data. At least one (1) printed and one (1) electronic copy of the aggregate data shall be provided without charge to the Legislative Research Commission.]~~
- (4) Collection of data about individual patients shall ***include information commonly used to identify an individual for assigning a unique patient identifier. Upon assigning a unique patient identifier, all direct identifying information shall be stripped from the data and shall not be retained by the cabinet or the cabinet's designee***~~[be in a nonidentifying numeric form and shall not include a patient's name or Social Security number. Any person who receives information identifying a patient through error or any other means shall return all copies of the information immediately].~~
- (5) All data and information collected shall be kept in a secure location and under lock and key when specifically responsible personnel are absent.
- (6) Only designated cabinet staff shall have access to raw data and information. The designated staff shall be made aware of their responsibilities to maintain confidentiality. Staff with access to raw data and information shall sign a statement indicating that the staff person accepts responsibility to hold that data or identifying information in confidence and is aware of penalties under state or federal law for breach of confidentiality. Data which, because of small sample size, breaches the confidence of individual patients, shall not be released.

- (7) Any employee of the cabinet who violates any provision of this section shall be fined not more than five hundred dollars (\$500) for each violation or be confined in the county jail for not more than six (6) months, or both, and shall be removed and disqualified from office or employment.

➔Section 2. KRS 216.380 is amended to read as follows:

- (1) The licensure category of critical access hospital is hereby created for existing licensed acute-care hospitals which qualify under this section for that status.
- (2) It shall be unlawful to operate or maintain a critical access hospital without first obtaining a license from the Cabinet for Health and Family Services. An acute-care hospital converting to a critical access hospital shall not require a certificate of need. A certificate of need shall not be required for services provided on a contractual basis in a critical access hospital. A certificate of need shall not be required for an existing critical access hospital to increase its acute-care bed capacity to twenty-five (25) beds.
- (3) Except as provided in subsection (4) of this section, only a hospital licensed as a general acute-care hospital may be relicensed as a critical access hospital if:
- (a) The hospital is located in a county in a rural area that is:
1. Located more than a thirty-five (35) mile drive, or, where the terrain is mountainous or only secondary roads are available, located more than a fifteen (15) mile drive, from another acute-care hospital or critical access hospital; or
 2. Certified by the secretary as a necessary provider of health care services to area residents;
- (b) For the purposes of paragraph (a) of this subsection, a hospital shall be considered to be located in a rural area if the hospital is not in a county which is part of a standard metropolitan statistical area, the hospital is located in a rural census tract of a metropolitan statistical area as determined under the most recent modification of the Goldsmith Modification, or is designated by the state as a rural provider. The secretary shall designate a hospital as a rural provider if the hospital is not located in a county which has the largest county population of a standard metropolitan statistical area;
- (c) Except as provided in paragraph (d) of this subsection, the hospital provides not more than twenty-five (25) acute care inpatient beds for providing acute inpatient care for a period that does not exceed, as determined on an annual, average basis, ninety-six (96) hours;
- (d) If the hospital is operating swing beds under which the hospital's inpatient hospital facilities are used for the provision of extended care services, the hospital may be designated as a critical access hospital so long as the total number of beds that may be used at any time for furnishing of either extended care services or acute inpatient services does not exceed twenty-five (25) beds. For the purposes of this section, any bed of a unit of the hospital that is licensed as a nursing facility at the time the hospital applies to the state for designation as a critical care access hospital shall not be counted.
- (4) The secretary for health and family services may designate a facility as a critical access hospital if the facility:
- (a) Was a hospital that ceased operations on or after ten (10) years prior to April 21, 2000; or
- (b) Was a hospital that was converted to a licensed ~~primary care center, rural health clinic,~~ ambulatory health center~~[-]~~ or other type of licensed health clinic or health center and, as of the effective date of that conversion, meets the criteria for licensure as a critical access hospital under this subsection or subsection (3) of this section.
- (5) A critical access hospital shall provide the following services:
- (a) Twenty-four (24) hour emergency-room care that the secretary determines is necessary for insuring access to emergency care services in each area served by a critical access hospital; and
- (b) Basic laboratory, radiologic, pharmacy, and dietary services. These services may be provided on a part-time, off-site contractual basis.
- (6) A critical access hospital may provide the following services:
- (a) Swing beds or a distinct unit of the hospital which is a nursing facility in accordance with KRS Chapter 216B and subject to approval under certificate of need;
- (b) Surgery;
- (c) Normal obstetrics;

- (d) Primary care;
 - (e) Adult day health care;
 - (f) Respite care;
 - (g) Rehabilitative and therapeutic services including, but not limited to, physical therapy, respiratory therapy, occupational therapy, speech pathology, and audiology, which may be provided on an off-site contractual basis;
 - (h) Ambulatory care;
 - (i) Home health services which may be established upon obtaining a certificate of need; and
 - (j) Mobile diagnostic services with equipment not exceeding the major medical equipment cost threshold pursuant to KRS Chapter 216B and for which there are no review criteria in the State Health Plan.
- (7) In addition to the services that may be provided under subsection (6) of this section, a critical access hospital may establish the following units in accordance with applicable Medicare regulations and subject to certificate of need approval:
- (a) A psychiatric unit that is a distinct part of the hospital, with a maximum of ten (10) beds; and
 - (b) A rehabilitation unit that is a distinct part of the hospital, with a maximum of ten (10) beds notwithstanding any other bed limit contained in law or regulation.
- (8) Psychiatric unit and rehabilitation unit beds operated under subsection (7) of this section shall not be counted in determining the number of beds or the average length of stay of a critical access hospital for purposes of applying the bed and average length of stay limitations under paragraph (c) of subsection (3) of this section.
- (9) The following staffing plan shall apply to a critical access hospital:
- (a) The hospital shall meet staffing requirements as would apply under section 1861(e) of Title XVIII of the Federal Social Security Act to a hospital located in a rural area except that:
 - 1. The hospital need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the hospital shall be open and fully staffed, except insofar as the facility is required to make available emergency services and nursing services available on a twenty-four (24) hour basis; and
 - 2. The hospital need not otherwise staff the facility except when an inpatient is present; and
 - (b) Physician assistants and nurse practitioners may provide inpatient care within the limits of their statutory scope of practice and with oversight by a physician who is not required to be on-site at the hospital.
- (10) A critical access hospital shall have a quality assessment and performance improvement program and procedures for review of utilization of services.
- (11) A critical access hospital shall have written contracts assuring the following linkages:
- (a) Secondary and tertiary hospital referral services which shall provide for the transfer of a patient to the appropriate level of care and the transfer of patients to the critical access hospital for recuperative care;
 - (b) Ambulance services;
 - (c) Home health services; and
 - (d) Nursing facility services if not provided on-site.
- (12) If the critical access hospital is part of a rural health network, the hospital shall have the following:
- (a) An agreement for patient referral and transfer, development, and use of communications systems including telemetry and electronic sharing of patient data, and emergency and nonemergency transportation; and
 - (b) An agreement for credentialing and quality assurance with a network hospital, peer review organization, or other appropriate and qualified entity identified in the state rural health plan.

- (13) The Cabinet for Health and Family Services and any insurer or managed care program for Medicaid recipients that contracts with the Department for Medicaid Services for the receipt of Federal Social Security Act Title XIX funds shall provide for reimbursement of services provided to Medicaid recipients in a critical access hospital at rates that are at least equal to those established by the Federal Health Care Financing Administration or Centers for Medicare and Medicaid Services for Medicare reimbursement to a critical access hospital.
- (14) The Cabinet for Health and Family Services shall promulgate administrative regulations pursuant to KRS Chapter 13A necessary to implement this section.

➔Section 3. KRS 216.510 is amended to read as follows:

As used in KRS 216.515 to 216.530:

- (1) "Long-term-care facilities" means those health-care facilities in the Commonwealth which are defined by the Cabinet for Health and Family Services to be family-care homes, personal-care homes, intermediate-care facilities,~~skilled-nursing facilities,~~ nursing facilities~~as defined in Pub. L. 100-203,~~ nursing homes, and **intermediate care facilities for individuals with intellectual disabilities**~~intermediate care facilities for the intellectually and developmentally disabled~~.
- (2) "Resident" means any person who is admitted to a long-term-care facility as defined in KRS 216.515 to 216.530 for the purpose of receiving personal care and assistance.
- (3) "Cabinet" means the Cabinet for Health and Family Services.

➔Section 4. KRS 216.535 is amended to read as follows:

- (1) As used in KRS 216.537 to 216.590:

- (a) "Long-term care facilities" means those health care facilities in the Commonwealth which are defined by the Cabinet for Health and Family Services to be family care homes, personal care homes, intermediate care facilities,~~skilled-nursing facilities,~~ nursing facilities~~as defined in Pub. L. 100-203,~~ nursing homes, and intermediate care facilities for **individuals with intellectual disabilities**~~the intellectually and developmentally disabled~~;
- (b) "Cabinet" means the Cabinet for Health and Family Services;
- (c) "Resident" means any person admitted to a long-term care facility as defined by this section;
- (d) "Licensee" in the case of a licensee who is an individual means the individual, and in the case of a licensee who is a corporation, partnership, or association means the corporation, partnership, or association;
- (e) "Secretary" means the secretary of the Cabinet for Health and Family Services;
- (f) "Long-term care ombudsman" means the person responsible for the operation of a long-term care ombudsman program which investigates and resolves complaints made by or on behalf of residents of long-term care facilities; and
- (g) "Willful interference" means an intentional, knowing, or purposeful act or omission which hinders or impedes the lawful performance of the duties and responsibilities of the ombudsman as set forth in this chapter.
- (2) The following information shall be available upon request of the affected Medicaid recipient or responsible party:
- (a) Business names, business addresses, and business telephone numbers of operators and administrators of the facility; and
- (b) Business names, business addresses, and business telephone numbers of staff physicians and the directors of nursing.
- (3) The following information shall be provided to the nursing facility patient upon admission:
- (a) Admission and discharge policies of the facility;
- (b) Payment policies relevant to patients for all payor types; and
- (c) Information developed and distributed to the nursing facility by the Department for Medicaid Services, including but not limited to:

1. Procedures for implementation of all peer review organizations' reviews and appeals processes;
2. Eligibility criteria for the state's Medical Assistance Program, including circumstances when eligibility may be denied; and
3. Names and telephone numbers for case managers and all state long term care ombudsmen.

➔Section 5. KRS 216.545 is amended to read as follows:

- (1) The cabinet shall prepare a statement of the requirements of KRS 216.537 and 216.540 which shall become part of the public notice required to be posted in each facility in accordance with KRS 216.543.
- (2) All long-term care facilities shall provide every resident, upon admission, with a personal copy of the statement required in subsection (1) of this section. ~~[- In the case of current residents, a statement shall be provided within ninety (90) days after July 15, 1982. -]~~

➔Section 6. KRS 216.563 is amended to read as follows:

The cabinet shall *promulgate administrative* ~~[- within six (6) months of July 15, 1982, upon consultation with industry, professional and consumer groups affected by KRS 216.537 to 216.590, publish proposed]~~ regulations setting forth the criteria and, where feasible, the specific acts that constitute Type A and B violations as specified by KRS 216.537 to 216.590. ~~[- The criteria shall be reviewed at least quarterly for the purpose of more clearly defining the specific acts or circumstances which constitute Type A and B violations. -]~~ No violation or civil penalty for violations of KRS 216.537 to 216.590 shall be assessed until the initial regulations are effective pursuant to KRS Chapter 13A.

➔Section 7. KRS 216.577 is amended to read as follows:

Upon a finding that conditions in a long-term care facility constitute a Type A violation, and the licensee fails to correct the violation within the time specified for correction by the cabinet, the secretary shall take at least one (1) of the following actions with respect to the facility in addition to the issuance of a citation, or the assessment of a civil penalty therefor:

- (1) Institute proceedings to obtain an order compelling compliance with the regulations, standards, or requirements as set forth by the *Cabinet for Health and Family Services* ~~[- Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~, the provisions of KRS 216.510 to 216.525, or applicable federal laws and regulations governing the certification of a long-term care facility under Title 18 or 19 of the Social Security Act;
- (2) Institute injunctive proceedings in Circuit Court to terminate the operation of the facility; or
- (3) Selectively transfer residents whose care needs are not being adequately met by the long-term care facility.

➔Section 8. KRS 216.595 is amended to read as follows:

- (1) (a) Any assisted-living community as defined by KRS 194A.700 ~~or~~ ~~[-]~~ long-term care facility as defined in KRS 216.535 ~~[- or long term care facility constructed under KRS 216B.071]~~ that claims to provide special care for persons with a medical diagnosis of Alzheimer's disease or other brain disorders shall maintain a written and current manual that contains the information specified in subsection (2) of this section. This manual shall be maintained in the office of the community's or facility's director and shall be made available for inspection upon request of any person. The community or facility shall make a copy of any program or service information contained in the manual for a person who requests information about programs or services, at no cost to the person making the request.
- (b) Any advertisement of the community or facility shall contain the following statement: "Written information relating to this community's or facility's services and policies is available upon request."
- (c) The community or facility shall post a statement in its entrance or lobby as follows: "Written information relating to this community's or facility's services and policies is available upon request."
- (2) The community or facility shall maintain and update written information on the following:
 - (a) The assisted-living community's or long-term care facility's mission or philosophy statement concerning the needs of residents with Alzheimer's disease or other brain disorders;
 - (b) The process and criteria the assisted-living community or long-term care facility uses to determine placement into services for persons with Alzheimer's disease or other brain disorders;

- (c) The process and criteria the assisted-living community or long-term care facility uses to transfer or discharge persons from special services for Alzheimer's or other brain disorders;
 - (d) The supervision provided for residents with a medical diagnosis of Alzheimer's disease or other brain disorders;
 - (e) The family's role in care;
 - (f) The process for assessing, planning, implementing, and evaluating the plan of care for persons with Alzheimer's disease or other brain disorders;
 - (g) A description of any special care services for persons with Alzheimer's disease or other brain disorders;
 - (h) Any costs associated with specialized services for Alzheimer's disease or other brain disorders; and
 - (i) A description of dementia or other brain disorder-specific staff training that is provided, including but not limited to the content of the training, the number of offered and required hours of training, the schedule for training, and the staff who are required to complete the training.
- (3) An assisted-living community may request a waiver from the Cabinet for Health and Family Services regarding building requirements to address the specialized needs of individuals with Alzheimer's disease or other brain disorders.

➔Section 9. KRS 216B.015 is amended to read as follows:

Except as otherwise provided, for purposes of this chapter, the following definitions shall apply:

- (1) "Abortion facility" means any place in which an abortion is performed;
- (2) "Administrative regulation" means a regulation adopted and promulgated pursuant to the procedures in KRS Chapter 13A;
- (3) "Affected persons" means the applicant; any person residing within the geographic area served or to be served by the applicant; any person who regularly uses health facilities within that geographic area; health facilities located in the health service area in which the project is proposed to be located which provide services similar to the services of the facility under review; health facilities which, prior to receipt by the agency of the proposal being reviewed, have formally indicated an intention to provide similar services in the future; and the cabinet and third-party payors who reimburse health facilities for services in the health service area in which the project is proposed to be located;
- (4) (a) "Ambulatory surgical center" means a health facility:
 - 1. Licensed pursuant to administrative regulations promulgated by the cabinet;
 - 2. That provides outpatient surgical services, excluding oral or dental procedures; and
 - 3. Seeking recognition and reimbursement as an ambulatory surgical center from any federal, state, or third-party insurer from which payment is sought.
- (b) An ambulatory surgical center does not include the private offices of physicians where in-office outpatient surgical procedures are performed as long as the physician office does not seek licensure, certification, reimbursement, or recognition as an ambulatory surgical center from a federal, state, or third-party insurer.
- (c) Nothing in this subsection shall preclude a physician from negotiating enhanced payment for outpatient surgical procedures performed in the physician's private office so long as the physician does not seek recognition or reimbursement of his or her office as an ambulatory surgical center without first obtaining a certificate of need or license required under KRS 216B.020 and 216B.061;
- (5) "Applicant" means any physician's office requesting a major medical equipment expenditure *exceeding the capital expenditure minimum* ~~of one million five hundred thousand dollars (\$1,500,000) or more after July 15, 1996, adjusted annually~~, or any person, health facility, or health service requesting a certificate of need or license;
- (6) "Cabinet" means the Cabinet for Health and Family Services;
- (7) "Capital expenditure" means an expenditure made by or on behalf of a health facility which:
 - (a) Under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance or is not for investment purposes only; or

- (b) Is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part thereof;
- (8) "Capital expenditure minimum" means *the annually adjusted amount set by the cabinet*~~{one million five hundred thousand dollars (\$1,500,000) beginning with July 15, 1994, and as adjusted annually thereafter}~~. In determining whether an expenditure exceeds the expenditure minimum, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the improvement, expansion, or replacement of any plant or any equipment with respect to which the expenditure is made shall be included. Donations of equipment or facilities to a health facility which if acquired directly by the facility would be subject to review under this chapter shall be considered a capital expenditure, and a transfer of the equipment or facilities for less than fair market value shall be considered a capital expenditure if a transfer of the equipment or facilities at fair market value would be subject to review;
- (9) "Certificate of need" means an authorization by the cabinet to acquire, to establish, to offer, to substantially change the bed capacity, or to substantially change a health service as covered by this chapter;
- (10) "Certified surgical assistant" means a certified surgical assistant or certified first assistant who is certified by the National Surgical Assistant Association on the Certification of Surgical Assistants, the Liaison Council on Certification of Surgical Technologists, or the American Board of Surgical Assistants. The certified surgical assistant is an unlicensed health-care provider who is directly accountable to a physician licensed under KRS Chapter 311 or, in the absence of a physician, to a registered nurse licensed under KRS Chapter 314;
- (11) "Continuing care retirement community" means a community that provides, on the same campus, a continuum of residential living options and support services to persons sixty (60) years of age or older under a written agreement. The residential living options shall include independent living units, nursing home beds, and either assisted living units or personal care beds;
- (12) "Formal review process" means the ninety (90) day certificate-of-need review conducted by the cabinet;
- (13) "Health facility" means any institution, place, building, agency, or portion thereof, public or private, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, nursing, rehabilitative, or preventive care and includes alcohol abuse, drug abuse, and mental health services. This shall include but shall not be limited to health facilities and health services commonly referred to as hospitals, psychiatric hospitals, physical rehabilitation hospitals, chemical dependency programs,~~{tuberculosis hospitals, skilled nursing facilities,}~~ nursing facilities, nursing homes, personal care homes, intermediate care facilities, family care homes,~~{primary care centers, rural health clinics,}~~ outpatient clinics, ambulatory care facilities, ambulatory surgical centers, emergency care centers and services, ambulance providers, hospices, community *mental health* centers~~{for mental health or individuals with an intellectual disability}~~, home health agencies, kidney disease treatment centers and freestanding hemodialysis units,~~{facilities and services owned and operated by health maintenance organizations directly providing health services subject to certificate of need,}~~ and others providing similarly organized services regardless of nomenclature;
- (14) "Health services" means clinically related services provided within the Commonwealth to two (2) or more persons, including but not limited to diagnostic, treatment, or rehabilitative services, and includes alcohol, drug abuse, and mental health services;
- (15) "Independent living" means the provision of living units and supportive services, including but not limited to laundry, housekeeping, maintenance, activity direction, security, dining options, and transportation;
- (16) "Intraoperative surgical care" includes the practice of surgical assisting in which the certified surgical assistant or physician assistant is working under the direction of the operating physician as a first or second assist, and which may include the following procedures:
- (a) Positioning the patient;
 - (b) Preparing and draping the patient for the operative procedure;
 - (c) Observing the operative site during the operative procedure;
 - (d) Providing the best possible exposure of the anatomy incident to the operative procedure;
 - (e) Assisting in closure of incisions and wound dressings; and

- (f) Performing any task, within the role of an unlicensed assistive person, or if the assistant is a physician assistant, performing any task within the role of a physician assistant, as required by the operating physician incident to the particular procedure being performed;
- (17) "Major medical equipment" means equipment which is used for the provision of medical and other health services and which costs in excess of the medical equipment expenditure minimum. ~~For purposes of this subsection, "medical equipment expenditure minimum" means one million five hundred thousand dollars (\$1,500,000) beginning with July 15, 1994, and as adjusted annually thereafter.~~ In determining whether medical equipment has a value in excess of the medical equipment expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of the equipment shall be included;
- (18) "Nonsubstantive review" means an expedited review conducted by the cabinet of an application for a certificate of need as authorized under KRS 216B.095;
- (19) "Nonclinically related expenditures" means expenditures for:
 - (a) Repairs, renovations, alterations, and improvements to the physical plant of a health facility which do not result in a substantial change in beds, a substantial change in a health service, or the addition of major medical equipment, and do not constitute the replacement or relocation of a health facility; or
 - (b) Projects which do not involve the provision of direct clinical patient care, including but not limited to the following:
 - 1. Parking facilities;
 - 2. Telecommunications or telephone systems;
 - 3. Management information systems;
 - 4. Ventilation systems;
 - 5. Heating or air conditioning, or both;
 - 6. Energy conservation; or
 - 7. Administrative offices;
- (20) "Party to the proceedings" means the applicant for a certificate of need and any affected person who appears at a hearing on the matter under consideration and enters an appearance of record;
- (21) "Perioperative nursing" means a practice of nursing in which the nurse provides preoperative, intraoperative, and postoperative nursing care to surgical patients;
- (22) "Person" means an individual, a trust or estate, a partnership, a corporation, an association, a group, state, or political subdivision or instrumentality including a municipal corporation of a state;
- (23) "Physician assistant" means the same as the definition provided in KRS 311.550;
- (24) "Record" means, as applicable in a particular proceeding:
 - (a) The application and any information provided by the applicant at the request of the cabinet;
 - (b) Any information provided by a holder of a certificate of need or license in response to a notice of revocation of a certificate of need or license;
 - (c) Any memoranda or documents prepared by or for the cabinet regarding the matter under review which were introduced at any hearing;
 - (d) Any staff reports or recommendations prepared by or for the cabinet;
 - (e) Any recommendation or decision of the cabinet;
 - (f) Any testimony or documentary evidence adduced at a hearing;
 - (g) The findings of fact and opinions of the cabinet or the findings of fact and recommendation of the hearing officer; and
 - (h) Any other items required by administrative regulations promulgated by the cabinet;
- (25) "Registered nurse first assistant" means one who:

- (a) Holds a current active registered nurse licensure;
- (b) Is certified in perioperative nursing; and
- (c) Has successfully completed and holds a degree or certificate from a recognized program, which shall consist of:
 - 1. The Association of Operating Room Nurses, Inc., Core Curriculum for the registered nurse first assistant; and
 - 2. One (1) year of postbasic nursing study, which shall include at least forty-five (45) hours of didactic instruction and one hundred twenty (120) hours of clinical internship or its equivalent of two (2) college semesters.

A registered nurse who was certified prior to 1995 by the Certification Board of Perioperative Nursing shall not be required to fulfill the requirements of paragraph (c) of this subsection;

- (26) "Secretary" means the secretary of the Cabinet for Health and Family Services;
- (27) "Sexual assault examination facility" means a licensed health facility, emergency medical facility, primary care center, or a children's advocacy center or rape crisis center that is regulated by the Cabinet for Health and Family Services, and that provides sexual assault examinations under KRS 216B.400;
- (28) "State health plan" means the document prepared triennially, updated annually, and approved by the Governor;
- (29) "Substantial change in a health service" means:
 - (a) The addition of a health service for which there are review criteria and standards in the state health plan; *or*
 - (b) The addition of a health service subject to licensure under this chapter; ~~or~~
 - ~~(c) The reduction or termination of a health service which had previously been provided in the health facility;~~
- (30) "Substantial change in bed capacity" means the addition *or* ~~[,] reduction[, relocation, or redistribution]~~ of beds by licensure classification within a health facility;
- (31) "Substantial change in a project" means a change made to a pending or approved project which results in:
 - (a) A substantial change in a health service, except a reduction or termination of a health service;
 - (b) A substantial change in bed capacity, except for reductions;
 - (c) A change of location; or
 - (d) An increase in costs greater than the allowable amount as prescribed by regulation;
- (32) "To acquire" means to obtain from another by purchase, transfer, lease, or other comparable arrangement of the controlling interest of a capital asset or capital stock, or voting rights of a corporation. An acquisition shall be deemed to occur when more than fifty percent (50%) of an existing capital asset or capital stock or voting rights of a corporation is purchased, transferred, leased, or acquired by comparable arrangement by one (1) person from another person;
- (33) "To batch" means to review in the same review cycle and, if applicable, give comparative consideration to all filed applications pertaining to similar types of services, facilities, or equipment affecting the same health service area;
- (34) "To establish" means to construct, develop, or initiate a health facility;
- (35) "To obligate" means to enter any enforceable contract for the construction, acquisition, lease, or financing of a capital asset. A contract shall be considered enforceable when all contingencies and conditions in the contract have been met. An option to purchase or lease which is not binding shall not be considered an enforceable contract; and
- (36) "To offer" means, when used in connection with health services, to hold a health facility out as capable of providing, or as having the means of providing, specified health services.

➔Section 10. KRS 216B.020 is amended to read as follows:

- (1) The provisions of this chapter that relate to the issuance of a certificate of need shall not apply to abortion facilities as defined in KRS 216B.015; any hospital which does not charge its patients for hospital services and does not seek or accept Medicare, Medicaid, or other financial support from the federal government or any state government; assisted living residences; family care homes; state veterans' nursing homes; services provided on a contractual basis in a rural primary-care hospital as provided under KRS 216.380; community mental health centers for services as defined in KRS Chapter 210; primary care centers; rural health clinics; private duty nursing services **operating**~~(licensed)~~ as nursing pools; group homes; licensed residential crisis stabilization units~~, which may be part of a licensed psychiatric hospital~~; licensed free-standing residential substance use disorder treatment programs with sixteen (16) or fewer beds, but not including Levels I and II psychiatric residential treatment facilities or licensed psychiatric inpatient beds; outpatient behavioral health treatment, but not including partial hospitalization programs; end stage renal disease dialysis facilities, freestanding or hospital based; swing beds; special clinics, including but not limited to wellness, weight loss, family planning, disability determination, speech and hearing, counseling, pulmonary care, and other clinics which only provide diagnostic services with equipment not exceeding the major medical equipment cost threshold and for which there are no review criteria in the state health plan; nonclinically related expenditures; nursing home beds that shall be exclusively limited to on-campus residents of a certified continuing care retirement community; home health services provided by a continuing care retirement community to its on-campus residents; the relocation of hospital administrative or outpatient services into medical office buildings which are on or contiguous to the premises of the hospital; ***the relocation of acute care beds which occur among acute care hospitals under common ownership and which are located in the same area development district so long as there is no substantial change in services and the relocation does not result in the establishment of a new service at the receiving hospital for which a certificate of need is required; the redistribution of beds by licensure classification within an acute care hospital so long as the redistribution does not increase the total licensed bed capacity of the hospital***; residential hospice facilities established by licensed hospice programs; or the following health services provided on site in an existing health facility when the cost is less than six hundred thousand dollars (\$600,000) and the services are in place by December 30, 1991: psychiatric care where chemical dependency services are provided, level one (1) and level two (2) of neonatal care, cardiac catheterization, and open heart surgery where cardiac catheterization services are in place as of July 15, 1990. The provisions of this section shall not apply to nursing homes, personal care homes, intermediate care facilities, and family care homes; or nonconforming ambulance services as defined by administrative regulation. These listed facilities or services shall be subject to licensure, when applicable.
- (2) Nothing in this chapter shall be construed to authorize the licensure, supervision, regulation, or control in any manner of:
- (a) Private offices and clinics of physicians, dentists, and other practitioners of the healing arts, except any physician's office that meets the criteria set forth in KRS 216B.015(5) or that meets the definition of an ambulatory surgical center as set out in KRS 216B.015;
 - (b) Office buildings built by or on behalf of a health facility for the exclusive use of physicians, dentists, and other practitioners of the healing arts; unless the physician's office meets the criteria set forth in KRS 216B.015(5), or unless the physician's office is also an abortion facility as defined in KRS 216B.015, except no capital expenditure or expenses relating to any such building shall be chargeable to or reimbursable as a cost for providing inpatient services offered by a health facility;
 - (c) ***Outpatient health facilities or health services that:***
 1. ***Do not provide services or hold patients in the facility after midnight; and***
 2. ***Are exempt from certificate of need and licensure under subsection (3) of this section;***
 - (d) Dispensaries and first-aid stations located within business or industrial establishments maintained solely for the use of employees, if the facility does not contain inpatient or resident beds for patients or employees who generally remain in the facility for more than twenty-four (24) hours;
 - ~~(e)(d)~~ Establishments, such as motels, hotels, and boarding houses, which provide domiciliary and auxiliary commercial services, but do not provide any health related services and boarding houses which are operated by persons contracting with the United States Department of Veterans Affairs for boarding services;
 - ~~(f)(e)~~ The remedial care or treatment of residents or patients in any home or institution conducted only for those who rely solely upon treatment by prayer or spiritual means in accordance with the creed or

tenets of any recognized church or religious denomination and recognized by that church or denomination; and

~~(g)(f)~~ On-duty police and fire department personnel assisting in emergency situations by providing first aid or transportation when regular emergency units licensed to provide first aid or transportation are unable to arrive at the scene of an emergency situation within a reasonable time.

(3) *The following outpatient categories of care shall be exempt from certificate of need and licensure on the effective date of this Act:*

- (a) *Primary care centers;*
- (b) *Special health clinics, unless the clinic provides pain management services and is located off the campus of the hospital that has majority ownership interest;*
- (c) *Specialized medical technology services, unless providing a State Health Plan service;*
- (d) *Retail-based health clinics and ambulatory care clinics that provide non-emergency, non-invasive treatment of patients;*
- (e) *Ambulatory care clinics treating minor illnesses and injuries;*
- (f) *Mobile health services, unless providing a service in the State Health Plan;*
- (g) *Rehabilitation agencies;*
- (h) *Rural health clinics; and*
- (i) *Off-campus, hospital-acquired physician practices.*

(4) *The exemption established by subsections (2) and (3) of this section shall not apply to the following categories of care:*

- (a) *An ambulatory surgical center as defined by KRS 216B.015(4);*
- (b) *A health facility or health service that provides one (1) of the following types of services:*
 - 1. *Cardiac catheterization;*
 - 2. *Megavoltage radiation therapy;*
 - 3. *Adult day health care;*
 - 4. *Behavioral health services;*
 - 5. *Chronic renal dialysis;*
 - 6. *Birthing services; or*
 - 7. *Emergency services above the level of treatment for minor illnesses or injuries;*
- (c) *A pain management facility as defined by KRS 218A.175(1);*
- (d) *An abortion facility that requires licensure pursuant to KRS 216B.0431; or*
- (e) *A health facility or health service that requests an expenditure that exceeds the major medical expenditure minimum.*

(5) An existing facility licensed as ~~an~~~~skilled-nursing,~~ intermediate care~~[-]~~ or nursing home shall notify the cabinet of its intent to change to a nursing facility as defined in Public Law 100-203. A certificate of need shall not be required for conversion of ~~an~~~~skilled-nursing,~~ intermediate care~~[-]~~ or nursing home to the nursing facility licensure category.

~~[(4) Notwithstanding any other provision of law to the contrary, dual license acute care beds licensed as of December 31, 1995, and those with a licensure application filed and in process prior to February 10, 1996, may be converted to nursing facility beds by December 31, 1996, without applying for a certificate of need. Any dual license acute care beds not converted to nursing facility beds by December 31, 1996, shall, as of January 1, 1997, be converted to licensed acute care beds.~~

~~(5) Notwithstanding any other provision of law to the contrary, no dual license acute care beds or acute care nursing home beds that have been converted to nursing facility beds pursuant to the provisions of subsection~~

~~(3) of this section may be certified as Medicaid eligible after December 31, 1995, without the written authorization of the secretary.~~

~~(6) Notwithstanding any other provision of law to the contrary, total dual license acute care beds shall be limited to those licensed as of December 31, 1995, and those with a licensure application filed and in process prior to February 10, 1996. No acute care hospital may obtain a new dual license for acute care beds unless the hospital had a licensure application filed and in process prior to February 10, 1996.~~

~~(6)~~~~(7)~~ Ambulance services owned and operated by a city government, which propose to provide services in coterminous cities outside of the ambulance service's designated geographic service area, shall not be required to obtain a certificate of need if the governing body of the city in which the ambulance services are to be provided enters into an agreement with the ambulance service to provide services in the city.

~~(7)~~~~(8)~~ Notwithstanding any other provision of law, a continuing care retirement community's nursing home beds shall not be certified as Medicaid eligible unless a certificate of need has been issued authorizing applications for Medicaid certification. The provisions of subsection ~~(5)~~~~(3)~~ of this section notwithstanding, a continuing care retirement community shall not change the level of care licensure status of its beds without first obtaining a certificate of need.

➔Section 11. KRS 216B.035 is amended to read as follows:

- (1) The cabinet shall hire any administrative staff required by the cabinet to carry out its duties and functions under the provisions of this chapter.
- (2) The secretary shall keep a full and true record of all the proceedings of the cabinet, of all books and papers ordered filed by the cabinet, and of all exemptions and certificates of need issued by the cabinet *in paper or electronic form*, and shall be responsible to it for the safe custody and preservation of all documents in its possession. The secretary may administer oaths in all parts of the state, where the exercise of that power is properly incidental to the performance of the duties of the cabinet under this chapter.

➔Section 12. KRS 216B.040 is amended to read as follows:

- (1) The cabinet shall have four (4) separate and distinct functions in administering this chapter:
 - (a) To approve or deny certificates of need in accordance with the provisions of this chapter, except as to those applications which have been granted nonsubstantive review status by the cabinet;
 - (b) To issue and to revoke certificates of need;
 - (c) To provide a due process hearing and issue a final determination on all actions by the cabinet to deny, revoke, modify, or suspend licenses of health facilities and health services issued by the cabinet; and
 - (d) To enforce, through legal actions on its own motion, the provisions of this chapter and its orders and decisions issued pursuant to its functions.
- (2) The cabinet shall:
 - (a) Promulgate administrative regulations pursuant to the provisions of KRS Chapter 13A:
 1. To establish the certificate of need review procedures, including but not limited to, application procedures, notice provisions, procedures for review of completeness of applications, and timetables for review cycles.
 2. To establish criteria for issuance and denial of certificates of need which shall be limited to the following considerations:
 - a. Consistency with plans. Each proposal approved by the cabinet shall be consistent with the state health plan, and shall be subject to biennial budget authorizations and limitations, and with consideration given to the proposal's impact on health care costs in the Commonwealth. The state health plan shall contain a need assessment for long-term care beds, which shall be based on a statistically valid analysis of the present and future needs of the state as a whole and counties individually. The need assessment shall be applied uniformly to all areas of the state. The methodology shall be reviewed and updated on an annual basis. The long-term care bed need criteria in the state health plan or as set forth by the appropriate certificate of need authority shall give preference to conversion of personal care beds and acute care beds to nursing facility beds, so long as the state health plan or the appropriate certificate of need authority establishes a need in the affected

counties and the proposed conversions are more cost-effective than new construction. The fact that the state health plan shall not address the specific type of proposal being reviewed shall not constitute grounds for disapproval of the proposal. Notwithstanding any other provision of law, the long-term care bed need criteria in the state health plan or as set forth by the appropriate certificate of need authority shall not consider, factor in, or include any continuing care retirement community's nursing home beds established under KRS 216B.015, 216B.020, 216B.330, and 216B.332;

- b. Need and accessibility. The proposal shall meet an identified need in a defined geographic area and be accessible to all residents of the area. A defined geographic area shall be defined as the area the proposal seeks to serve, including its demographics, and shall not be limited to geographical boundaries;
 - c. Interrelationships and linkages. The proposal shall serve to accomplish appropriate and effective linkages with other services, facilities, and elements of the health care system in the region and state, accompanied by assurance of effort to achieve comprehensive care, proper utilization of services, and efficient functioning of the health care system;
 - d. Costs, economic feasibility, and resources availability. The proposal, when measured against the cost of alternatives for meeting needs, shall be judged to be an effective and economical use of resources, not only of capital investment, but also ongoing requirements for health manpower and operational financing;
 - e. Quality of services. The applicant shall be prepared to and capable of undertaking and carrying out the responsibilities involved in the proposal in a manner consistent with appropriate standards and requirements assuring the provision of quality health care services, as established by the cabinet;
 - f. Hospital-based skilled nursing, intermediate care, and personal care beds shall be considered by the cabinet in determining the need for freestanding long-term care beds.
- (b) Conduct public hearings, as requested, in respect to certificate-of-need applications, revocations of certificates of need, and denials, suspensions, modifications, or revocations of licenses.
- (3) The cabinet may:
- (a) Issue other administrative regulations necessary for the proper administration of this chapter;
 - (b) Administer oaths, issue subpoenas, subpoenas duces tecum, and all necessary process in proceedings brought before or initiated by the cabinet, and the process shall extend to all parts of the Commonwealth. Service of process in all proceedings brought before or initiated by the cabinet may be made by certified mail, or in the same manner as other process in civil cases, as the cabinet directs;
 - (c) Establish by promulgation of administrative regulation under KRS Chapter 13A reasonable application fees for certificates of need;
 - (d) ~~Appoint technical advisory committees as are deemed necessary to administer its functions under the provisions of this chapter;~~
 - ~~(e)~~ Establish a mechanism for issuing advisory opinions to prospective applicants for certificates of need regarding the requirements of a certificate of need; and
 - ~~(e)~~ Establish a mechanism for biennial review of projects for compliance with the terms of the certificate of need.

→Section 13. KRS 216B.055 is amended to read as follows:

Notice of decisions and orders made by the cabinet under the provisions of this chapter shall be made by certified mail addressed to the last known address on file with the cabinet, ~~for~~ by personal service, **or other method of delivery which may include electronic service**. The notice shall be mailed, or personal service **or other method of delivery** shall be obtained, no later than fifteen (15) working days after the decision or order. Notice shall be complete and effective upon mailing **or delivery**.

→Section 14. KRS 216B.105 is amended to read as follows:

- (1) Unless otherwise provided in this chapter, no person shall operate any health facility in this Commonwealth without first obtaining a license issued by the cabinet, which license shall specify the kind or kinds of health services the facility is authorized to provide. A license shall not be transferable and shall be issued for a specific location and, if specified, a designated geographical area.
- (2) The cabinet may deny, revoke, modify, or suspend a license in any case in which it finds that there has been a substantial failure to comply with the provisions of this chapter or the administrative regulations promulgated hereunder. The denial, revocation, modification, or suspension shall be effected by mailing to the applicant or licensee, by certified mail *or other method of delivery which may include electronic service*, a notice setting forth the particular reasons for the action. The denial, revocation, modification, or suspension shall become final and conclusive thirty (30) days after notice is given, unless the applicant or licensee, within the thirty (30) day period, shall file a request in writing for a hearing with the cabinet.
- (3) The hearing shall be before a person designated to serve as hearing officer by the secretary.
- (4) Within thirty (30) days from the conclusion of the hearing, the findings and recommendations of the hearing officer shall be transmitted to the cabinet, with a synopsis of the evidence contained in the record and a statement of the basis of the hearing officer's findings. The applicant or licensee shall be entitled to be represented at the hearing in person or by counsel, or both, and shall be entitled to introduce testimony by witnesses or, if the cabinet so permits, by depositions. A full and complete record shall be kept of all hearings, and all testimony shall be reported but need not be transcribed unless the decision is appealed pursuant to this chapter. The cabinet may adopt the hearing officer's findings and recommendations or prepare written findings of fact and state the basis for its decision which shall become part of the record of the proceedings.
- (5) All decisions revoking, suspending, modifying or denying licenses shall be made by the cabinet in writing. The cabinet shall notify the applicant or licensee of the decision.
- (6) The decision of the cabinet shall be final for purposes of judicial appeal upon notice of the cabinet's decision.

➔Section 15. KRS 314.027 is amended to read as follows:

- (1) Funding for the Kentucky nursing incentive scholarship fund shall be supplied partly by funds received from penalties and fines, to include, but not be limited to, certificate of need penalties assessed on ~~primary care centers, hospitals, nursing facilities, and skilled and intermediate care~~ nursing homes, **personal care homes, and family care homes** under the provisions of KRS 216.560 and 216B.131(2).
- (2) Additional funding shall be provided by an assessment of five dollars (\$5) to be added to each nurse licensure renewal application fee payable to the board, proceeds of which shall be annually allocated to the Kentucky nursing incentive scholarship fund.
- (3) The board may cancel any contract between it and any applicant or recipient upon failure by the applicant or recipient to meet requirements of KRS 314.025 to 314.027 or board administrative regulations. Failure to complete the terms of the contract shall subject the applicant to legal action for the recovery of all assistance provided, together with attorney fees and interest at a compound rate of eight percent (8%) from the date of disbursement from the Kentucky nursing incentive scholarship fund.

➔Section 16. KRS 311.550 is amended to read as follows:

As used in KRS 311.530 to 311.620 and KRS 311.990(4) to (6):

- (1) "Board" means the State Board of Medical Licensure;
- (2) "President" means the president of the State Board of Medical Licensure;
- (3) "Secretary" means the secretary of the State Board of Medical Licensure;
- (4) "Executive director" means the executive director of the State Board of Medical Licensure or any assistant executive directors appointed by the board;
- (5) "General counsel" means the general counsel of the State Board of Medical Licensure or any assistant general counsel appointed by the board;
- (6) "Regular license" means a license to practice medicine or osteopathy at any place in this state;
- (7) "Limited license" means a license to practice medicine or osteopathy in a specific institution or locale to the extent indicated in the license;

- (8) "Temporary permit" means a permit issued to a person who has applied for a regular license, and who appears from verifiable information in the application to the executive director to be qualified and eligible therefor;
- (9) "Emergency permit" means a permit issued to a physician currently licensed in another state, authorizing the physician to practice in this state for the duration of a specific medical emergency, not to exceed thirty (30) days;
- (10) Except as provided in subsection (11) of this section, the "practice of medicine or osteopathy" means the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities;
- (11) The "practice of medicine or osteopathy" does not include the practice of Christian Science, the domestic administration of family remedies, the rendering of first aid or medical assistance in an emergency in the absence of a person licensed to practice medicine or osteopathy under the provisions of this chapter, the use of automatic external defibrillators in accordance with the provisions of KRS 311.665 to 311.669, the practice of podiatry as defined in KRS 311.380, ~~the practice of a midlevel health care practitioner as defined in KRS 216.900,~~ the practice of dentistry as defined in KRS 313.010, the practice of optometry as defined in KRS 320.210, the practice of chiropractic as defined in subsection (2) of KRS 312.015, the practice as a nurse as defined in KRS 314.011, the practice of physical therapy as defined in KRS 327.010, the practice of genetic counseling as defined in KRS 311.690, the performance of duties for which they have been trained by paramedics licensed under KRS Chapter 311A, first responders, or emergency medical technicians certified under Chapter 311A, the practice of pharmacy by persons licensed and registered under KRS 315.050, the sale of drugs, nostrums, patented or proprietary medicines, trusses, supports, spectacles, eyeglasses, lenses, instruments, apparatus, or mechanisms that are intended, advertised, or represented as being for the treatment, correction, cure, or relief of any human ailment, disease, injury, infirmity, or condition, in regular mercantile establishments, or the practice of midwifery by women. KRS 311.530 to 311.620 shall not be construed as repealing the authority conferred on the Cabinet for Health and Family Services by KRS Chapter 211 to provide for the instruction, examination, licensing, and registration of all midwives through county health officers;
- (12) "Physician" means a doctor of medicine or a doctor of osteopathy;
- (13) "Grievance" means any allegation in whatever form alleging misconduct by a physician;
- (14) "Charge" means a specific allegation alleging a violation of a specified provision of this chapter;
- (15) "Complaint" means a formal administrative pleading that sets forth charges against a physician and commences a formal disciplinary proceeding;
- (16) As used in KRS 311.595(4), "crimes involving moral turpitude" shall mean those crimes which have dishonesty as a fundamental and necessary element, including but not limited to crimes involving theft, embezzlement, false swearing, perjury, fraud, or misrepresentation;
- (17) "Telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education;
- (18) "Order" means a direction of the board or its panels made or entered in writing that determines some point or directs some step in the proceeding and is not included in the final order;
- (19) "Agreed order" means a written document that includes but is not limited to stipulations of fact or stipulated conclusions of law that finally resolves a grievance, a complaint, or a show cause order issued informally without expectation of further formal proceedings in accordance with KRS 311.591(6);
- (20) "Final order" means an order issued by the hearing panel that imposes one (1) or more disciplinary sanctions authorized by this chapter;
- (21) "Letter of agreement" means a written document that informally resolves a grievance, a complaint, or a show cause order and is confidential in accordance with KRS 311.619;
- (22) "Letter of concern" means an advisory letter to notify a physician that, although there is insufficient evidence to support disciplinary action, the board believes the physician should modify or eliminate certain practices and that the continuation of those practices may result in action against the physician's license;

- (23) "Motion to revoke probation" means a pleading filed by the board alleging that the licensee has violated a term or condition of probation and that fixes a date and time for a revocation hearing;
- (24) "Revocation hearing" means a hearing conducted in accordance with KRS Chapter 13B to determine whether the licensee has violated a term or condition of probation;
- (25) "Chronic or persistent alcoholic" means an individual who is suffering from a medically diagnosable disease characterized by chronic, habitual, or periodic consumption of alcoholic beverages resulting in the interference with the individual's social or economic functions in the community or the loss of powers of self-control regarding the use of alcoholic beverages;
- (26) "Addicted to a controlled substance" means an individual who is suffering from a medically diagnosable disease characterized by chronic, habitual, or periodic use of any narcotic drug or controlled substance resulting in the interference with the individual's social or economic functions in the community or the loss of powers of self-control regarding the use of any narcotic drug or controlled substance;
- (27) "Provisional permit" means a temporary permit issued to a licensee engaged in the active practice of medicine within this Commonwealth who has admitted to violating any provision of KRS 311.595 that permits the licensee to continue the practice of medicine until the board issues a final order on the registration or reregistration of the licensee;
- (28) "Fellowship training license" means a license to practice medicine or osteopathy in a fellowship training program as specified by the license; and
- (29) "Special faculty license" means a license to practice medicine that is limited to the extent that this practice is incidental to a necessary part of the practitioner's academic appointment at an accredited medical school program or osteopathic school program and any affiliated institution for which the medical school or osteopathic school has assumed direct responsibility.

➔Section 17. 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, gastrointestinal, and food allergic conditions, consisting of therapeutic food, formulas, supplements, amino acid-based elemental formula, 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;
 23. Argininemia;
 24. Food protein allergies;
 25. Food protein-induced enterocolitis syndrome;
 26. Eosinophilic disorders; and
 27. Short bowel syndrome;
- (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)
 - (a) The Medical Assistance Program shall use the appropriate form and guidelines for enrolling those providers 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. A Medicaid managed care organization shall use the forms and guidelines established under KRS 304.17A-545(5) to credential a provider. For any provider who contracts with and is credentialed by a Medicaid managed care organization prior to enrollment, the cabinet shall complete the enrollment process and deny, or approve and issue a Provider Identification Number (PID) within fifteen (15) business days from the time all necessary completed enrollment forms have been submitted and all outstanding accounts receivable have been satisfied.
 - (b) Within forty-five (45) days of receiving a correct and complete provider application, the Department for Medicaid Services shall complete the enrollment process by either denying or approving and issuing a Provider Identification Number (PID) for a behavioral health provider who provides substance use disorder services, unless the department notifies the provider that additional time is needed to render a decision for resolution of an issue or dispute.
 - (c) Within forty-five (45) days of receipt of a correct and complete application for credentialing by a behavioral health provider providing substance use disorder services, a Medicaid managed care organization shall complete its contracting and credentialing process, unless the Medicaid managed care organization notifies the provider that additional time is needed to render a decision. If additional time is needed, the Medicaid managed care organization shall not take any longer than ninety (90) days from receipt of the credentialing application to deny or approve and contract with the provider.
 - (d) A Medicaid managed care organization shall adjudicate any clean claims submitted for a substance use disorder service from an enrolled and credentialed behavioral health provider who provides substance use disorder services in accordance with KRS 304.17A-700 to 304.17A-730.

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

- 216.600 Pilot project to provide preventive oral care services to nursing home residents.
- 216.860 Definitions for KRS 216.865.
- 216.865 Licensing required -- Administrative regulations.
- 216.900 Definitions for KRS 216.900 to 216.930.
- 216.905 Network license required.
- 216.910 Powers and duties of network.
- 216.915 Administrative regulations.
- 216.930 Linkage agreements.
- 216B.071 Long-term care facilities for patients with Alzheimer's disease exempt from certificate of need.
- 216B.120 Judicial appeals -- Bonds -- Costs.
- 216B.176 School-located health care or dental care programs provided by not-for-profit primary care centers at public school or Head Start program.
- 216B.177 Moratorium -- Establishment of additional satellite school-based health care programs.

Signed by Governor April 10, 2018.