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KENTUCKY ADMINISTRATIVE REGULATIONS are codified according to the following system and are to be cited by Title, Chapter and Regulation number, as follows:

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Board
201 KAR 42:020. Fees. (Comments Received) Withdrawn; SOC not filed, 1-15-2013
201 KAR 42:035. Application process, exam, and curriculum requirements. (Comments Received) Withdrawn; SOC not filed, 1-15-2013
201 KAR 42:040. Renewal. (Comments Received) Withdrawn; SOC not filed, 1-15-2013
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701 KAR 5:140. Districts of Innovation. (Comments Received; SOC ext.)

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Filing and Publication

Administrative bodies shall file with the Regulations Compiler all proposed administrative regulations, public hearing and comment period information, regulatory impact analysis and tiering statement, fiscal note, federal mandate comparison, and incorporated material information. Those administrative regulations received by the deadline established in KRS 13A.050 shall be published in the Administrative Register.

Public Hearing and Public Comment Period

The administrative body shall schedule a public hearing on proposed administrative regulations which shall not be held before the 21st day or later than the last workday of the month of publication. Written comments shall also be accepted until the end of the calendar month in which the administrative regulation was published.

The administrative regulation shall include: the place, time, and date of the hearing; the manner in which persons may submit notification to attend the hearing and written comments; that notification to attend the hearing shall be sent no later than 5 workdays prior to the hearing date; the deadline for submitting written comments; and the name, position, address, and telephone and fax numbers of the person to whom notification and written comments shall be sent.

The administrative body shall notify the Compiler, by phone and letter, whether the hearing was held or cancelled and whether written comments were received. If the hearing was held or written comments were received, the administrative body shall file a statement of consideration with the Compiler by the fifteenth day of the calendar month following the month of publication.

A transcript of the hearing is not required unless a written request for a transcript is made, and the person requesting the transcript shall have the responsibility of paying for same. A recording may be made in lieu of a transcript.

Review Procedure

After the public hearing and public comment period processes are completed, the administrative regulation shall be reviewed by the Administrative Regulation Review Subcommittee at its next meeting. After review by the Subcommittee, the administrative regulation shall be referred by the Legislative Research Commission to an appropriate jurisdictional committee for a second review. The administrative regulation shall be considered as adopted and in effect as of adjournment on the day the appropriate jurisdictional committee meets or 30 days after being referred by LRC, whichever occurs first.
Section 1. Child Assessment. (1) Assessment shall be an ongoing procedure used by personnel meeting the qualifications established in 902 KAR 30:150 Section (2)(a)-(p) throughout the child’s period of eligibility for First Steps. An assessment shall reflect:

(a) The child’s unique strengths and needs; and
(b) The services appropriate to meet those needs;
(c) The family’s resources, priorities and concerns which shall be:
1. Voluntary on the part of the family;
2. Family-directed; and
3. Based on information provided by the family through personal interview; and

(d) The supports and services necessary to enhance the family’s capacity to meet the developmental needs of the child’s family.

(2) All evaluations and assessments of the child and family shall be conducted in a nondiscriminatory manner and selected and administered so as not to be racially or culturally discriminatory.

(3) Unless clearly not feasible to do so, all assessments of a child shall be conducted in the native language of the child.

(4) Assessments shall be ecologically valid and reflect appropriate multisource and multimeasures. One (1) source or one (1) measure shall not be used as the sole criterion for determining an intervention program.

(a) Assessment methods shall include direct assessment and at least one (1) of the following:
1. Observations;
2. Interview and parent reports; or

(b) Direct assessment shall include one (1) or more instruments that are:
1. Appropriate for an infant or toddler and allow for adaptations for a disability as needed; and
2. Criterion-referenced, which compares the child’s level of development with skills listed in a chronological sequence of typical development.

(5) If, after the initial evaluation and assessments are completed, the IFSP team determines that a subsequent assessment is warranted, the following shall be documented on the IFSP:

(a) The IFSP team’s reasons for an additional assessment;
(b) Whether a current provider on the IFSP team can assess the area or areas of concern; and
(c) Circumstances relating to the child’s ability or the family’s capacity to address the child’s developmental needs that warrant the subsequent assessment.

(6) POE staff [44] A service coordinator shall obtain a physician's or advanced practice registered nurse’s (APRN’s) written approval in order to complete an assessment on a child deemed medically fragile. The approval shall be specific as to the modifications needed to accommodate the child’s medical status.

(7) If a formal, direct assessment shall include a written report if performed for initial assessment, the annual assessment, or exit assessment [progress monitoring], or if authorized by the IFSP in accordance with subsection (3) of this section. This report shall include:

(a) A description of the assessment instruments used in accordance with subsection (4)(b) (2)(b) of this section;
(b) A description of the assessment activities and the information obtained, including information gathered from the family;
(c) Identifying information, including:
1. The child’s First Steps identification number;
2. The name of the child;
3. The child’s age at the date of the assessment;
4. The name of the service provider and discipline;
5. The date of the assessment;
6. The setting of the assessment;
7. The state of health of the child during the assessment;
8. The parent’s assessment of the child’s performance in comparison to abilities demonstrated by the child in more familiar circumstances;
9. The medical diagnosis if the child has an established risk condition;
10. [The formal and informal instruments and assessment methods and activities used; and
11. Who was present for the assessment; and
12. A profile of the child’s level of performance, in a narrative form which shall indicate the:
1. Concerns and priorities;
2. Child’s unique strengths, needs, and preferences;
3. Skills achieved since the last report, if applicable;
4. Current and emerging skills, including skills performed independently and with assistance; and
5. Recommended direction for future service delivery [and

6. Recommendations that address the family’s priorities as well as the child’s holistic needs based on the review of pertinent medical, social, and developmental information, the evaluation, and the assessment].

(8) Item level data from [6] A copy of the cabinet-approved criterion referenced assessment protocol shall be submitted electronically to the Kentucky Early Childhood Data System within five [10] calendar days of the completion of the assessment.

(9) [The initial or other formal assessments, with written reports, shall be completed and recorded in the child’s record using the First Steps data management system within five [15] calendar days of the provider completing the assessment.

(b) The provider who performed the assessment shall:
1. Verbally share the assessment report with the family and shall document the contact in the assessor’s notes;

2. Provide the written report to the family [and the service coordinator] within the time frame established in paragraph (a) of this subsection; and

3. Write the report in family-appropriate language that the child’s family can easily understand.

(c) If the time frame established in paragraph (a) of this subsection is not met due to illness of the child or a request by the parent, the assessor shall document the delay circumstances in staff notes with supportive documentation made in the child’s record by the service coordinator [and the report shall be provided to the service coordinator within five (5) calendar days of completing the assessment].

10) [8] An assessment provided as a general practice of a discipline, not due to the child or family’s needs, shall be considered an early intervention, one:

(b) Ongoing assessment shall ensure that the IFSP and services are flexible and accessible.

11) [9] Ten (10) calendar days prior to either the annual or six
(6) month review of the IFSP or the expiration date of the IFSP, a service provider shall complete [supply] progress reports in the online data management system and provide a copy to the family [to the primary service coordinator and family].

1. (2)(c)(2)(a) Within thirty (30) [420] days prior to exiting the First Steps program at age three (3), each child shall receive an assessment in all five (5) developmental domains by the Primary Service Provider (PSP) using a cabinet-approved criterion referenced instrument.

(b) The assessment used for annual redetermination of eligibility may be used to meet the assessment required by paragraph (a) of this subsection if it is completed within ninety (90) [480] days prior to the child's exit from the First Steps Program.

Section 2. Family Assessment. (1) The family assessment shall be conducted with the family of a child eligible for early intervention services to identify the family's resources, priorities, and concerns for their child.

(2) The identification of the family's resources, priorities and concerns shall be:

(a) Voluntary on the part of the family;

(b) Family directed;

(c) Based on information provided by the family through an assessment tool and personal interview with those members who elect to participate in the assessment; and

(d) Used to determine the supports and services necessary to enhance the family's capacity to meet the developmental needs of the eligible child.

(3) Unless clearly not feasible to do so, the family assessment shall be conducted in the native language of the family members being assessed.

(4) POE staff shall provide a written report of the family assessment to the family within five (5) calendar days of the parent interview.

(5) The family assessment report shall contain recommendations that address the family's priorities as well as the child's holistic needs based on the review of pertinent medical, social, and developmental information.

(6) The family assessment shall be updated prior to the six (6) month IFSP meeting and shall be re-administered prior to the annual IFSP meeting.

Section 3. Individualized Family Service Plan (IFSP). (1) For a child who has been evaluated for the first time and determined eligible in accordance with 902 KAR 30:120, a meeting to develop the initial IFSP shall be conducted within forty-five (45) days after the point of entry receives the referral.

(2) At the IFSP meeting, the IFSP shall be reviewed by convening a meeting at least every six (6) months. An IFSP team meeting shall be convened more frequently if:

(a) A periodic IFSP review meeting is requested by:

1. The family; or
2. The family and a team member; or
(b) An early intervention service is added or increased.

(3) The signed IFSP shall be a contract between the family and service providers. A service included on the IFSP shall be provided as authorized, unless the family chooses not to receive the service and this choice is documented in the child's record.

(4) The IFSP shall include:

(a) Information about the child's present level of developmental functioning; information shall cover the following domains:

1. Physical development that includes fine and gross motor skills, vision, hearing, and general health status;

2. Cognitive development that includes skills related to the child's mental development and includes basic sensorimotor skills, as well as preacademic skills;

3. Communication development that includes skills related to exchanging information or feelings, including receptive and expressive communication and communication with peers and adults;

4. Social and emotional development that includes skills related to the ability of the child to successfully and appropriately select and carry out their interpersonal goals; and

5. Adaptive development that includes self-help skills and the ability of the child's sensory systems to integrate successfully for independent functions;

(b) Performance levels to determine strengths which can be used to enhance functional skills in daily routines when planning instructional strategies to teach skills;

(c) A description of:

1. Underlying factors that may affect the child's development including the established risk condition; and

2. What motivates the child, as determined on the basis of observation in natural settings, during child interaction, and through parent report;

(d) With concurrence of the family, a statement of the family's resources, priorities, and concerns related to enhancing the development of the child;

(e) A statement of the measurable results or measurable outcomes expected to be achieved for the child (including pre-literacy and language skills as developmentally appropriate for the child) and family, and the criteria, procedures, and time lines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary. Outcome statements shall:

1. Be functionally stated;

2. Be representative of the family's own priorities;

3. Fit naturally into the family's routines or schedules;

4. Reflect the use of the family's own resources and social support network; and

5. Be flexible to meet the child and family's needs in current and possible future environments;

(f) At least one (1) measurable transition outcome that addresses any upcoming changes relevant to the child and family or, if the child is two (2) years or older addresses transition to preschool or other related services, and includes:

1. A description of types of information the family might need to assist in preparing for the upcoming changes and in relation to future placements;

2. Activities to be used to help prepare the child for changes in the service delivery;

3. Specific steps that will help the child adjust to and function in the new setting; and

4. A description of information that will be shared with the new setting, timelines to share the information, and ways to secure the necessary releases to refer and transmit records to the next placement;

(g) The statement of the specific early intervention services, based on peer-reviewed research to the extent practicable, that are necessary to meet the unique needs of the child and family to achieve the results or outcomes. Service authorizations shall be stated in length, frequency, intensity, duration, location, and methods of delivering services, and shall include payment arrangements:

(b) 1. A description of the natural environment, which includes natural settings and service delivery systems, in which the early intervention service is to be provided; and

2. How the skills shall be transferred to a caregiver so that the caregiver can incorporate the strategies and activities into the child's natural environment;

3. How the child's services may be integrated into a setting in which other children without disabilities participate; and

4. If the service cannot be provided in a natural environment, the reason, including:

a. Why the early intervention service cannot be achieved satisfactorily in a natural environment;

b. How the service is supported by the peer reviewed research;

c. How the service provided in this location or using this approach will support the child's ability to function in his or her natural environment; and

d. A timeline as to when the service might be expected to be delivered in a natural environment approach;

(i) The dates for initiation of the services and the anticipated duration of those services;

(j) Other services that the child needs that are not early intervention services, such as medical services or housing for the family. The funding sources and providers to be used for those services or the steps that will be taken to secure those services through public or private resources shall be identified;
(k) The name of the service coordinator representing the child's or family's needs and the primary service provider. The service coordinator shall be responsible for the implementation of the IFSP and coordination with other agencies and persons in accordance with 902 KAR 30:110, Section 2.

(i) A review of the Family Rights Handbook; and

(m) A statement signed by the parent that complies with KRS 200.664(6).

(5) The IFSP shall be finalized within five (5) working days of the meeting.

(6)(a) An authorized IFSP shall be valid for a period not to exceed six (6) months. An amendment that is made to the IFSP shall be valid for the remaining period of the plan.

(b) A parent or guardian's signature on the IFSP shall constitute written consent for early intervention services.

(7) In the development and implementation of the IFSP, IFSP team members shall:

(a) Provide a family-centered approach to early intervention;

(b) Honor the racial, ethnic, cultural, and socioeconomic diversity of families;

(c) Show respect for and acceptance of the diversity of family-centered early intervention;

(d) Allow families to choose the level and nature of their involvement in early intervention services;

(e) Facilitate and promote family and professional collaboration and partnerships, which are the keys to family-centered early intervention and to successful implementation of the IFSP process;

(f) Plan and implement the IFSP using a team approach;

(g) Reexamine their traditional roles and practices and develop new practices as appropriate that promote mutual respect and partnerships which may include a transdisciplinary approach;

(h) Determine the settings for service delivery based on the child's results or outcomes that are identified by the team; and

(i) Ensure that families have access and knowledge of services that shall:

1. Be provided in as normal a fashion and environment as possible;

2. Promote the integration of the child and family within the community;

3. Be embedded in the family's normal routines and activities; and

4. Be conducted in the family's natural environment, if possible, and in a way that services promote integration into a community setting which includes children without disabilities.

(8) If an agency or professional not participating on the IFSP team but active in the child's life makes a recommendation for an early intervention service, it shall not be provided as a First Steps service unless:

(a) The IFSP team:

1. Considers the recommendation;

2. Determines that it relates to a chosen outcome or result, and family priority;

3. Agrees that it is a necessary service; and

(b) The service is not covered by another payor source. (4)

(4) The signed IFSP shall be a contract between the family and service providers. A service included on the IFSP shall be provided as authorized, unless the family chooses not to receive the service and this choice is documented in the child's record.

(2) The IFSP shall be completed within five (5) calendar days of the meeting and shall include:

(a) Appropriate evaluation and assessment reports in accordance with 902 KAR 30:120, Section 2;

(b) A statement of the specific early intervention services, founded on scientifically based research to the extent practicable, necessary to meet the unique needs of the child and the family to achieve the outcomes identified, including the frequency, intensity, and method of delivering the services;

(c) Service delivery settings; and

(d) A list of IFSP team members and how they participated in the meeting.

(3)(a) An authorized IFSP shall be valid for a period not to exceed six (6) months. An amendment that is made to the IFSP shall be valid for the remaining period of the plan.

(b) A parent or guardian's signature on the IFSP shall constitute written consent for early intervention services.

(4) If the family or service provider is unable to keep a scheduled appointment due to illness or any other reason, the service provider shall document the circumstances in staff notes.

(5) In the development and implementation of the IFSP, IFSP team members shall:

(a) Provide a family-centered approach to early intervention;

(b) Honor the racial, ethnic, cultural, and socioeconomic diversity of families;

(c) Show respect for and acceptance of the diversity of family-centered early intervention;

(d) Allow families to choose the level and nature of their involvement in early intervention services;

(e) Facilitate and promote family and professional collaboration and partnerships, which are the keys to family-centered early intervention and to successful implementation of the IFSP process;

(f) Plan and implement the IFSP using a team approach;

(g) Reexamine their traditional roles and practices and develop new practices as appropriate that promote mutual respect and partnerships which may include a transdisciplinary approach;

(h) Ensure that First Steps services are flexible, accessible, founded on scientifically based research to the extent practicable, and are necessary to meet the unique needs of the child and family to achieve the outcomes identified, including the frequency, intensity, and method of delivery of the services; and

(i) Ensure that families have access and knowledge of services that shall:

1. Be provided in as normal a fashion and environment as possible;

2. Promote the integration of the child and family within the community;

3. Be embedded in the family's normal routines and activities; and

4. Be conducted in the family's natural environment, if possible, and in a way that services promote integration into a community setting which includes children without disabilities.

(6) For a child who has been evaluated for the first time and determined eligible in accordance with 902 KAR 30:120, a meeting to develop the initial IFSP shall be conducted within forty-five (45) days after the point of entry receives the referral.

(7) The IFSP shall be reviewed by convening a meeting at least every six (6) months. An IFSP team meeting shall be convened more frequently if:

(a) A periodic IFSP review meeting is requested by:

1. The family; or

2. The family and a team member; or

(b) An early intervention service is added or increased.

(8) The IFSP shall include:

(a) 1. A summary of the Family Rights Handbook;

2. A signed Statement of Assurance—Procedural Safeguards by the family; and

3. A statement signed by the parent that complies with KRS 200.664(6);

(b) Information about the child's present level of developmental functioning. Information shall cover the following domains:

1. Physical development that includes fine and gross motor skills, vision, hearing, and general health status;

2. Cognitive development that includes skills related to a child's mental development and includes basic sensorimotor skills, as well as preacademic skills;

3. Communication development that includes skills related to exchanging information, or feelings, including receptive and expressive communication and communication with peers and adults;

4. Social and emotional development that includes skills related to the ability of infants and toddlers to successfully and appropriately select and carry out their interpersonal goals; and

5. Adaptive development that includes self-help skills and the ability of the child's sensory systems to integrate successfully for independent functions;

(c) Performance levels to determine strengths which can be used to enhance functional skills in daily routines when planning instructional strategies to teach skills;

(d) A description of:

1. Underlying factors that may affect the child's development
including the established risk condition; and

2. What motivates the child, as determined on the basis of observation in appropriate natural settings, during child interaction, and through parent report;

3. With concurrence of the family, a statement of the family's resources, priorities, and concerns related to enhancing the development of the child;

4. A description of the major outcomes expected to be achieved for the child and family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made; and whether modifications or revisions of the outcomes or services are necessary. Outcome statements shall:

1. Be functionally stated;
2. Be representative of the family's own priorities;
3. Fit naturally into the family's routines or schedules;
4. Reflect the use of the family's own resources and social support network; and

5. Be flexible to meet the child and family's needs in expanded current and possible future environments;

(g) The specific First Steps services necessary to meet the unique needs of the child and family to achieve the outcomes;

1. Service documentation shall be stated in frequency, intensity, duration, location, and method of delivering services, and shall include payment arrangements, if any; and

2. With the concurrence of group intervention, and unless prior authorization is granted in accordance with 902 KAR 30-200, Section 4, based on individual needs of the child, the frequency and intensity for early intervention for each child shall not exceed one (1) hour per discipline per day for the following disciplines:
   a. Audiologist;
   b. RN or LPN;
   c. Nutritionist or dietician;
   d. Occupational therapist or occupational therapist assistant;
   e. Orientation and mobility specialist;
   f. Physical therapist or physical therapist assistant;
   g. Psychologist, psychological practitioner, certified psychologist with autonomous functioning, psychological associate, family therapist, licensed social worker, or licensed professional clinical counselor;
   h. Speech language pathologist;
   i. Vision specialist including a teacher of the visually impaired;
   j. Teacher of the deaf and hard of hearing; or
   k. Developmental interventionist;

(h) 1. A description of the natural environment, which includes natural settings and service delivery systems, in which the early intervention service is to be provided;

2. How the service shall be transferred to a caregiver so that the caregiver can incorporate the strategies and activities into the child's natural environment;

3. How the child's services may be integrated into a setting in which other children without disabilities participate; and

4. If the service cannot be provided in a natural environment, the reason including;

a. Why the early intervention service cannot be achieved satisfactorily in a natural environment;

b. How the service is supported by the peer reviewed research;

c. How the service provided in this location or using this approach will support the child's ability to function in his or her natural environment; and

d. A timeline as to when the service might be expected to be delivered in a natural environment approach;

(i) The projected dates for initiation of the services, and the anticipated length, duration, and frequency of those services;

(ii) Other services that the child needs that are not early intervention services, such as medical services or housing for the family. The funding sources and providers to be used for those services or the steps that will be taken to secure those services through public or private resources shall be identified;

(k) The name of the service coordinator representing the child's or family's needs and the primary service provider. The service coordinator shall be responsible for the implementation of the IFSP and coordination with other agencies and persons in accordance with 902 KAR 30:110, Section 2.

(l) At least one (1) transition outcome that addresses transition to preschool services to the extent that those are appropriate or to other services that may be available, if appropriate, as a part of every IFSP and is supported by steps that may include:

1. A description of types of information the family might need in relation to future placements;

2. Activities to be used to help prepare the child for changes in the service delivery;

3. Specific steps that will help the child adjust to and function in the new setting;

4. How and when assistive technology equipment will be reutilized and how it will be replaced in the next setting, if appropriate; and

5. A description of information that will be shared with the new setting, timelines to share the information, and ways to secure the necessary releases to refer and transmit records to the next placement; and

(m) Documentation substantiating the following if the child is being provided group intervention;

1. If the child is enrolled in day care or attending a group during normal routines, why the early intervention cannot be provided in the child's current group setting; and

2. Early intervention during group shall be directly related to the child's individualized strategies and activities as identified on the IFSP.

(f) If the IFSP team determines that an early intervention service shall be provided using a transdisciplinary team approach, the IFSP provider notes and progress documentation shall include:

(a) Which disciplines are providing the therapy using this approach;

(b) Evidence of transdisciplinary planning and practice, including documentation of how role-release is occurring;

(c) How the skills are being transferred so that one (1) provider is capable of providing the services previously provided by the team;

(d) Statements showing that the service is individualized to the particular family and child's needs; and

(e) If more than one (1) provider is present and providing early intervention services at the same time using a co-treatment approach:

1. Why this approach is being used;

2. The outcomes and activities;

3. Who is performing what activities; and

4. That the service providers involved are providing or learning about the early intervention at the same time.

(10) The family shall be encouraged to discuss the family's child's activities, strengths, and likes and dislikes exhibited at home;

(11) The IFSP shall highlight the child's abilities and strengths, rather than focusing just on the child's deficits;

(12) Every attempt shall be made to explain the child assessment process by using language the family uses and understands;

(13) The family may agree, disagree, or refute the assessment information;

(14) The family interpretation and perception of the assessment results shall be ascertained and the family's wishes and desires shall be documented as appropriate;

(15) If an agency or professional not participating on the IFSP team but active in the child's life makes a recommendation for an early intervention service, it shall not be provided as a First Steps service unless the IFSP team:

(a) Considers the recommendation;

(b) Determines that it relates to a chosen outcome, and family priority; and

(c) Agrees that it is a necessary service.

Section 4(3). Assistive Technology. (1) To access assistive technology services and devices, the child shall:

(a) Be eligible for First Steps; and

(b) Have the [a] need for and use of assistive technology devices and services documented in the IFSP.

(2) Prior to submitting a request for purchase of an assistive technology device the service coordinator shall attempt to obtain funding from at least two (2) sources outside the First Steps and
Medicaid systems. To be an approved assistive technology review team, an assistive technology center shall:

(a) Submit to the cabinet the credentials and documentation of experience in providing services to the birth to three (3) age population for each proposed team member; and

(b) Contract with the cabinet to conduct reviews of requests for assistive technology devices in accordance with this section.

(3) The First Steps assistive technology review team shall review:

(a) Each equipment request for which the purchase price exceeds $100; or

(b) A request submitted by the service coordinator, other POE staff, or state lead agency staff.

(4)(3) A request shall be processed within ten (10) calendar days of the receipt of required information. The required information shall include:

(a) A current IFSP;

(b) Assessments with recommendations;

(c) Justification statement for each device based on needs, including documentation of attempts to find alternative funding sources;

(d) Information regarding the equipment or device request, including information regarding the training of the family on the use of equipment; and

(e) Documentation of safety and approved uses in the birth to three (3) age population.

(5)(4) The decision made through the review process may be appealed to the Part C Coordinator who shall:

(a) Consult with the monitoring assistive technology review team; and

(b) Issue the final decision.

(6)(5) If the IFSP team is not in agreement with the decision of the Part C Coordinator:

(a) The child's IFSP team shall reconvene for an IFSP meeting with a representative from the assistive technology review team and a representative of the state lead agency; and

(b) If the IFSP team concludes at that IFSP meeting that the assistive technology device is still needed, payment for the device shall be authorized for the duration of the current IFSP.

(7) A request for purchase shall be made no later than ninety (90) days prior to the child's third birthday.

(8) Assistive technology devices purchased solely through First Steps funding shall be the property of the program. At the time the child exits the program, the family shall:

(a) Return the item to the POE office for the district where the child resides; or

(b) Purchase the item from the program at a depreciated cost.

(9) Assistive technology devices may be rented through a contracted assistive technology provider to:

(a) Determine the appropriateness of the requested item prior to purchase;

(b) Assist the child in achieving the IFSP outcomes or results; or

(c) Address short term needs of the child while awaiting receipt of a purchased device.

(10) The payment for assistive technology devices shall be made in accordance with 902 KAR 30:200 Section 2(5)(a) and (b).

(11) Items that cannot be returned for sanitary reasons, such as adapted utensils, shall not be rented.


(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Public Health, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

STEPHANIE MAYFIELD GIBSON, MD, FCAP, Commissioner
AUDREY HAYNES, Secretary

APPROVED BY AGENCY: December 12, 2012
FILED WITH LRC: December 12, 2012 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on January 22, 2013, at 9:00 a.m. in Conference Suite A, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by January 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is receive by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments regarding this proposed administrative regulation. You may submit written comments on the proposed administrative regulation until close of business January 31, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40621, phone 502-564-7905, fax 502-564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Paula Goff (502)564-3756

(1) Provide a brief summary of 902 KAR 30:120:

(a) What this administrative regulation does: This administrative regulation outlines new requirements for assistive technology devices. The regulation provides guidance and clarity for the implementation of the early intervention system in compliance with federal statute and regulations.

(b) The necessity of this administrative regulation: This regulation is necessary to provide guidance to service providers, primary level evaluation providers, intensive level evaluation teams and other service providers on child assessment, service planning, and assistive technology. Assistance is a service that all children in the Kentucky Early Intervention System receive and provides the foundational information to develop service plans. This regulation outlines new requirements for a family assessment. This regulation also lists the requirement for assistive technology service and devices.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 200.650(6) requires the state to be in compliance with federal statute and regulations. KRS 200.664 outlines the legal requirements for the development of an individualized family service plan.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation provides guidance and clarity for the implementation of the early intervention system in compliance with federal statute and regulation.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment to this regulation adds guidance for the required family assessment. It also provides greater detail for the requesting of assistive technology devices. The language regarding service planning is not new language but has been revised to align the state requirements to the newly released federal regulations.

(b) The necessity of the amendment to this administrative regulation: Language consistent with applicable federal regulations and statute is added to ensure compliance with federal regulation.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 200.650 (6) and KRS 200.652 (3) require a statewide system, comprehensive early intervention system that is in compliance with federal statute and regulation.

(d) How the amendment will assist in the effective administration of the statutes: The changes to this regulation will assist the state by creating a more streamlined system that is easier to support and monitor. The changes to the requirements for the IFSP will bring IFSPs into alignment with federal regulations. Also, regulations will now reflect the current practices assistive technology thus eliminating confusion between regulation and practice.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by the administr-
tive regulation: Approximately fifteen hundred (1500) early intervention providers, including Point of Entry staff, will be affected by these regulations. Over six thousand (6000) eligible children and their families will be affected by the service changes related to the regulations. No state or local governments are affected by the administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: The early intervention providers, including service coordinators, will need to learn and implement the amended regulations. Families currently receiving early intervention services will need to understand how the system operates so that they are informed consumers.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No additional costs will be associated with the amendment to this administrative regulation.

(c) As a result of the compliance, what benefits will accrue to the entities identified in question (3): The amended regulations will benefit early intervention providers, including service coordinators by providing needed clarity so that they are more effective in their roles within the system. Families will benefit by not undergoing unnecessary and duplicative testing and will be more informed consumers of the public services. This increased knowledge of the early intervention system may lead to increased supports and progress for their children.

(5) Provide an estimate of how much it will cost to implement this regulation:

(a) Initially: No new costs are incurred in implementing this regulation.

(b) On a continuing basis: No new costs are incurred in implementing this regulation.

(6) What is the source of the funding that will be used for the implementation and enforcement of the administrative regulation: Federal Part C funds and state general funds will be used to implement this administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary to implement this administrative regulation or its amendments.

(8) State whether or not this administrative regulation establishes an fees or directly or indirectly increases any fees: There is no direct or indirect increase in fees.

(9) TIERING: Is tiering applied? Tiering is not applied because First Steps regulations apply consistently across all children and families participating in the First Steps program as well as all providers participating in the First Steps program.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This administrative regulation impacts the 15 local Point of Entry, approx. 1500 direct service providers as well as the state administrative office that governs the First Steps program.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. 20 U.S.C. 1435, 1436, 1437; 34 C.F.R. Part 303; KRS 194A.050; KRS 200.650-676

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect:

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? There will be no new revenue generated by this administrative regulation during the first year.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? There will be no new revenue generated by this administrative regulation during the subsequent years.

(c) How much will it cost to administer this program for the first year? There will be no new expenditures to implement this administrative regulation during the first year.

(d) How much will it cost to administer this program for subsequent years? There will be no new expenditures to implement this administrative regulation during subsequent years.

Other Explanation: Changes to this administrative regulation will save an estimated $10,000 per year by reducing the number of unnecessary plan revisions and duplicate service assessments.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 34 C.F.R. 303.340 through 303.346 outlines the states responsibilities in the development and implementation of the Individual Family Service Plan. This amendment ensures full compliance with the provisions under that part.

2. State compliance standards KRS 200.664 charges the Cabinet for Health and Family Services, Department for Public Health with the development of the IFSP for eligible children.

3. Minimum or uniform standards contained in the federal mandate. By revising this administrative regulation Kentucky is in full compliance with the federal statutes.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This amendment does not impose stricter than federal requirements.

5. Justification for the imposition of stricter standard, or additional or different responsibilities or requirement. This amendment does not impose stricter than federal requirements.

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STATEMENT OF EMERGENCY
301 KAR 2:195E

This emergency administrative regulation establishes permitting, taking, possession, and reporting requirements for people engaged in falconry and raptor propagation in Kentucky. The U.S. Fish and Wildlife Service is requiring all states to assume the responsibility for oversight of falconry and raptor propagation. This directive requires all states to have a falconery exam, adequate regulations, and a means of tracking falconers and their birds within their state. This amended regulation meets the federal requirements. An ordinary administrative regulation will not suffice because the federal framework of reviewing and approving the new regulation did not allow sufficient time for our regulation to be reviewed and approved before January 1, 2013, which is a federal deadline. This emergency administrative regulation shall be replaced by an ordinary administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation. The ordinary administrative regulation will be filed with the Regulations Compiler by December 28, 2012.

STEVEN L. BESHEAR, Governor
BENJY KINMAN, Deputy Commissioner
For DR. JONATHAN GASSETT, Commissioner

TOURISM, ARTS AND HERITAGE CABINET
Kentucky Department of Fish and Wildlife Resources
(Emergency Amendment)

301 KAR 2:195E. Falconry, raptor take, and raptor propagation. [Raptor propagation and falconry.]

RELATES TO: KRS 150.010, 150.170, 150.180, 150.183, 150.200, 150.205, 150.220, 150.225, 150.230, 150.235, 150.265, 150.270, 150.300, 150.305, 150.310, 150.340, 150.360, [50 C.F.R. Parts 13, 17, 21, 22]

STATUTORY AUTHORITY: KRS 150.025(1), 150.280(1), [150.025, 150.028,] 50 C.F.R. Parts 13, 17, 21, 22

EFFECTIVE: December 28, 2012

NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations establishing open seasons for the taking of wildlife, bag limits, and methods of taking wildlife, and to make these requirements apply to a limited area. KRS 150.280(1) requires the department to promulgate administrative regulations establishing procedures for propagating and holding of protected wildlife, 50 C.F.R. Parts 13, 17, 21, and 22 establish requirements for permitting, taking, possessing, and selling of raptors and endangered and threatened species. This emergency administrative regulation establishes permitting, taking, possessing, and reporting requirements for people engaged in falconry and raptor propagation.

Section 1. Definitions. (1) “Adult raptor” means a raptor that is at least one (1) year old.
(2) “Captive-bred raptors” means a raptor or the eggs thereof, hatched in captivity from parents in captivity.
(3) “Eyases” means a young raptor that is still in the nest and not capable of flight.
(4) “Hack” means the temporary release of a raptor held for falconry to the wild so that it can survive on its own.
(5) “Hybrid raptor” means an offspring produced by two (2) distinct raptor species.
(6) “Imprinted” means a raptor that has been hand-raised by a human in isolation from the sight of other raptors from two (2) weeks of age through fledging.
(7) “Native raptor” means a raptor species which has historically existed or currently exists in the wild in Kentucky without introduction by humans.
(8) “Passage bird” means a raptor less than one (1) year of age that is capable of sustained flight and is no longer dependent on parental care.
(9) “Wild raptor” means a raptor that was originally taken from the wild.

Section 2. Federal Requirements. Except as established in Sections 3 through 11 of this administrative regulation, a person shall be in compliance with the federal requirements established in 50 C.F.R. Part:
(1) 13;
(2) 17;
(3) 21; and
(4) 22.

Section 3. Permits and Licenses. (1) A person shall be required to obtain and possess a falconry permit to take or possess a raptor for use in falconry.
(2) A person with a valid state or federal falconry permit:
(a) May take wildlife pursuant to applicable statewide requirements if the falconer:
1. Has a valid Kentucky hunting license; or
2. Is hunting license exempt pursuant to KRS 150.170; and
(b) Shall not be required to obtain a wildlife transportation permit pursuant to 301 KAR 2:841 and 2:842 if the person:
1. Is importing or transporting a legally held raptor into Kentucky; or
2. Is transporting a legally held falconry raptor into and through Kentucky to a destination outside of Kentucky.

Section 4. Falconry Permit Requirements. Classes of Permits, and Apprentice Sponsors. (1) To obtain a falconry permit of any class, a person shall:
(a) Complete a Kentucky Falconry Permit Application form provided by the Department; and
(b) Submit to the department:
1. The completed application;
2. The appropriate fee as established in 301 KAR 3:022; and
3. A completed Falconry Facilities and Equipment Inspection Report form signed by a state conservation officer.
(2) An apprentice falconry permit applicant shall:
(a) Be at least twelve (12) years old;
(b) Obtain a sponsor who holds a Kentucky general or master falconry permit pursuant to subsection (10) of this section;
(c) If under eighteen (18) years old, have a parent or legal guardian co-sign the application;
(d) Complete a Kentucky Falconry Permit Application form provided by the Department; and
(e) Pass the written examination by scoring a minimum of eighty (80) percent.
(3) An apprentice class falconry permit holder shall:
(a) Only possess one (1) of the following wild or captive-bred raptors at any given time:
1. American kestrel (Falco sparverius);
2. Red-tailed hawk (Buteo jamaicensis);
3. Red-shouldered hawk (Buteo lineatus); or
4. Harris’ hawk (Parabuteo unicinctus); and
(b) Not possess a raptor:
1. Taken from the wild as a nestling; or
2. That is imprinted on humans.
(4) A general class falconry permit applicant shall:
(a) Be at least sixteen (16) years old;
(b) If under eighteen (18) years old, have a parent or legal guardian co-sign the application;
(c) Have practiced falconry at the apprentice level for at least two (2) years; and
(d) Have complied with all previous year reporting requirements, if applicable, pursuant to Section 7 of this administrative regulation.
(5) A first time general class permit applicant shall also submit to the department:
(a) Signed document from a general or master class falconry permit holder stating that the permit applicant has:
1. Practiced falconry with a wild raptor at the apprentice level for at least two (2) years; and
2. Maintained, trained, and hunted with a raptor for an average of six (6) months per year with at least four (4) months in each year;

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(b) Summary of the species held as an apprentice; and
(c) The length of time the apprentice held each bird.
(6) A general class falconry permit holder shall:
(a) Be allowed to possess the following:
1. A raptor obtained from the wild;
2. A hybrid raptor; or
3. A captive-bred raptor; and
(b) Not possess more than three (3) of the following raptors at any given time:
   1. Great horned owl (Bubo virginianus); or
   2. Any member of the Order Falconiformes, except for the following species which shall not be possessed:
      a. Golden eagle (Aquila chrysaetos);
      b. Bald eagle (Haliaeetus leucocephalus);
      c. White-tailed eagle (Haliaeetus albicilla); or
      d. Stellar's sea eagle (Haliaeetus pelagicus).
(7) A master class falconry permit applicant shall:
(a) Have held a general class falconry permit for at least five years;
(b) Have complied with all previous year reporting requirements, pursuant to Section 7 of this administrative regulation.
(8) A first time master class permit applicant shall submit to the department a signed letter attesting that the applicant has practiced falconry at the general class permit level for at least five (5) years.
(9) A master class falconry permit holder:
(a) Shall not possess more than five (5) of the following wild raptors at any given time:
   1. Great horned owl; and
   2. Any member of the Order Falconiformes except a bald eagle;
(b) Shall obtain prior approval from the department pursuant to the requirements of 50 C.F.R. 21 and 22 to possess any of the following raptors:
   1. Golden eagle;
   2. White-tailed eagle; or
   3. Stellar's sea eagle; and
(c) May possess any number of captive-bred raptors of the species allowed in paragraph (a) and (b) of this subsection.
(10) An apprentice sponsor shall:
(a) Not have more than three (3) apprentices at any given time;
(b) Be at least eighteen (18) years old;
(c) Possess a valid Kentucky general or master class falconry permit;
(d) Have held a general class falconry permit for a minimum of two (2) years; and
(e) Submit a signed letter to the department:
1. Attesting that the sponsor will assist the apprentice in:
   a. Learning about the husbandry and training of raptors held for falconry;
   b. Learning relevant wildlife laws and regulations; and
   c. Deciding which species of raptor is most appropriate for the apprentice to possess; and
2. Containing the sponsor's:
   a. Name;
   b. Falconry permit number;
   c. Address; and
   d. Telephone number.
(11) A sponsor who is withdrawing sponsorship of an apprentice shall:
(a) Notify the department in writing within five (5) days of withdrawing the sponsorship; and
(b) Provide the apprentice with a signed and dated document stating the length of time that the apprentice practiced falconry under the sponsor's guidance.
(12) An apprentice who loses sponsorship shall obtain a new sponsor within thirty (30) days from the sponsor's notification of withdrawal.
(13) A new sponsor shall be in compliance with the requirements established in subsection (7) of this section.
(14) If an apprentice fails to obtain a new sponsor within thirty (30) days, the department shall:
(a) Revoke the apprentice's falconry permit; and
(b) Confiscate any raptor in the apprentice's possession if the apprentice does not transfer ownership of the raptor to another licensed falconer.
(15) A non-resident falconer who moves to Kentucky to establish residency shall apply for the appropriate Kentucky falconry permit within thirty (30) days after moving.
(16) A resident falconry applicant who is a new resident of the United States shall obtain the appropriate Kentucky falconry permit by:
(a) Meeting the application requirements established in subsection (1) of this section;
(b) Contacting the department to schedule a time to take a written examination administered by the department;
(c) Passing the written examination by scoring a minimum of eighty (80) percent; and
(d) Providing to the department written documentation of previous falconry experience including:
   1. The number of years the applicant has practiced falconry;
   2. The raptor species used in falconry; and
   3. The game species taken with falconry.
(17) A person who held a Kentucky falconry permit within the last five (5) years, but has allowed the permit to lapse, may apply for reinstatement at the class level previously held by:
(a) Complying with the application requirements established in subsection (1) of this section; and
(b) Providing the department with proof of previous certification at that class level.
(18) A person whose Kentucky falconry permit has lapsed for a period greater than five (5) years may apply for reinstatement at the class level previously held by:
(a) Complying with the application requirements established in subsection (1) of this section;
(b) Complying with the examination requirements established in subsection (2) of this section; and
(c) Providing the department with proof of previous certification at that class level.
(19) A falconry permit holder shall not be required to pay the permit fee established in 301 KAR 3:022 if the permit holder's current permit has not yet expired and the permit holder is applying for:
(a) An upgrade to the next falconry class; or
(b) A facility relocation.
Section 5. Facility, Equipment, and Care Requirements. (1) A falconry permit holder shall comply with all federal requirements established in 50 C.F.R. Part 21 for the permit holder's:
(a) Facility;
(b) Equipment; and
(c) Treatment and care for possessed raptors.
(2) A falconry permit holder who is relocating a raptor facility shall:
(a) Notify the department within five (5) business days of relocation; and
(b) Have a relocated raptor facility inspected and approved by a department conservation officer within thirty (30) days of relocation.
(3) A department conservation officer shall only inspect a raptor facility:
(a) In the presence of the permit holder;
(b) On a weekday; and
(c) Between 8 a.m. and 4:30 p.m. Eastern time.
(2) A falconry permit holder who is required by federal regulations to band a raptor shall:
(a) Contact the department to request leg bands at least fifteen (15) days prior to obtaining a raptor; and
(b) Only use U.S. Fish and Wildlife Service leg bands that are issued by the department.
(3) A falconry permit holder shall attach at least two (2) radio transmitters to a hybrid raptor if the permit holder is flying it untethered in the wild.
Section 7. Raptor Take and Release, Recordkeeping, and Reporting Requirements. (1) Unless exempted by KRS 150.170, a Kentucky falconry permit holder shall have in possession a Kentucky hunting license when taking a raptor from the wild.

(2) When taking a raptor from the wild, a nonresident shall have in possession:

(a) A valid Kentucky nonresident hunting license;
(b) A valid falconry permit or equivalent from the nonresident's home state; and
(c) An approved Kentucky Nonresident Raptor Take Form.

(3) To obtain a Kentucky Nonresident Raptor Take Form, a person shall:

(a) Print a copy of the form from the department's Web site at http://permits.fws.gov/186A; or

(b) Contact the department at 800-858-1549 and request a mailed copy.

(4) A person shall submit to the department a completed and signed Kentucky Nonresident Raptor Take Form at least fifteen (15) working days prior to the requested take date.

(5) A falconry permit holder shall be responsible for complying with all applicable federal requirements if taking raptors on federal land.

(6) A falconry permit holder who is a nonresident shall only take one (1) legal raptor in Kentucky per calendar year.

(7) An approved Kentucky Nonresident Raptor Take Form shall only be issued to a person whose state of residence allows a Kentucky resident to legally take a raptor from that state.

(8) A nonresident falconer who takes a raptor in Kentucky shall submit to the department a completed and signed Falconry Take Location Report within five (5) days of taking a bird.

(9) A licensed falconer shall comply with all raptor take requirements established in 50 C.F.R. 21 in addition to the requirements established in this section.

(10) A resident falconry permit holder shall not take more than two (2) raptors from the wild in any calendar year.

(11) An eyas shall only be taken:

(a) By a general or master class falconry permit holder; and

(b) From January 1 through July 31.

(12) A person shall not take more than one (1) sharp-shinned hawk (Accipiter striatus) eyas per calendar year.

(13) There shall be an annual maximum quota for sharp-shinned hawk eyases of:

(a) Ten (10) for Kentucky residents; and

(b) Five (5) for nonresidents.

(14) Prior to taking a sharp-shinned hawk eyas, a person shall be responsible for calling the department at 800-858-1549 to check if the sharp-shinned hawk eyas annual quota has been reached.

(15) A person shall not take a sharp-shinned hawk eyas from a nest unless there are at least three (3) eyases in the nest.

(16) Each person who takes a sharp-shinned hawk eyas shall submit to the department the Falconry Take Location Report within five (5) days of possession.

(17) Any permit class falconer may take a passage bird if it is a species the falconer is allowed to possess as established in Section 4 of this administrative regulation.

(18) The allowable period of take for:

(a) A passage bird, other than a great horned owl, is September 1 through January 31;

(b) An adult or passage bird great horned owl is September 1 through October 31; and

(c) An adult American kestrel shall only be taken from September 1 through January 31.

(19) An adult American kestrel or adult great horned owl shall only be taken by a:

(a) General class permit holder; or

(b) Master class permit holder.

(20) A person shall not take a peregrine falcon (Falco perigrinus) from the wild in Kentucky.

(21) A person shall not release the following raptors into the wild:

(a) A non-native raptor;

(b) A hybrid raptor; or

(c) A captive-bred, native raptor.

(22) Prior to releasing a raptor into the wild, a person shall remove all leg bands from the bird.

(23) A falconry permit holder shall complete and submit to the department a federal form 3-186A or enter the required information in the federal database at http://permits.fws.gov/186A within five (5) days if a raptor is:

(a) Acquired;

(b) Transferred;

(c) Released;

(d) Lost;

(e) Rebanded;

(f) Microchipped;

(g) Stolen; or

(h) Dead.

(24) A falconer shall retain copies of each submitted 3-186A form or the electronically submitted data for a minimum of five (5) years following a raptor's:

(a) Transfer;

(b) Release;

(c) Loss; or

(d) Death.

Section 8. Transfer of Ownership and Propagation. (1) A falconry permit holder may transfer ownership of a wild-caught raptor pursuant to 50 C.F.R. Part 21, but shall not engage in the following activities with wild-caught raptors:

(a) Selling;

(b) Purchasing;

(c) Trading; or

(d) Bartering.

(2) A falconry permit holder may transfer a wild-caught raptor to a person who possesses a federal raptor propagation permit if:

(a) The raptor has been used in falconry for at least one (1) year for the following species:

(a) Sharp-shinned hawk;

(b) Cooper's hawk (Accipter cooperii);

(c) Merlin (Falco columbarius); or

(d) American kestrel;

2. The raptor has been used in falconry for at least two (2) years for all other legal species of raptor; and

(b) The person receiving the transferred bird possesses a state captive wildlife permit.

(3) A person who legally possesses a captive-bred raptor may engage in the activities listed in subsection (1)(a) through (d) of this section if:

(a) The transferred bird is marked with a metal leg band; or

2. The transferred bird is implanted with a microchip pursuant to 50 C.F.R. Part 21; and

(b) The person in receipt of the bird possesses:

1. The appropriate class falconry permit; or

2. A federal raptor propagation permit.

(4) A person shall not breed or propagate a native raptor without first obtaining:

(a) A federal raptor propagation permit, pursuant to 50 C.F.R. Part 21; and

(b) The appropriate Kentucky captive wildlife permit, pursuant to 301 KAR 2:081.

(5) A person who is propagating a native raptor shall submit to the department copies of all the following materials required by 50 C.F.R. Part 21:

(a) The raptor propagation application;

(b) Propagation records; and

(c) Propagation reports.

(6) The materials required in subsection (5) of this section shall be submitted to the department by the same dates required in 50 C.F.R. Part 21.

Section 9. Other Activities. (1) A falconry permit holder may use a raptor for conservation education programs, pursuant to 50 C.F.R. Part 21.

(2) A falconry permit holder who is in compliance with the permit requirements for Special Purpose Abatement, pursuant to 50 C.F.R. Part 21, may receive payment for nuisance wildlife control work if the permit holder also possesses a Kentucky Commercial Nuisance Wildlife Control permit, pursuant to 301 KAR 3:120.
(3) A person may assist a permitted wildlife rehabilitator, as established in 301 KAR 2:075, in conditioning raptors for subsequent release into the wild if the person is:
(a) A general or master class falconry permit holder; and
(b) Working with a species the falconry permit holder is allowed to possess.
(4) A general or master class permit holder may hack a raptor if the permit holder contacts the Department and provides the following information:
(a) The hack site location;
(b) The species of raptor;
(c) The origin of the raptor; and
(d) The planned hacking dates.

Section 10. Revocation of Permits and Appeal Procedure. (1) The department shall revoke the falconry permit of a person convicted of a violation of this administrative regulation for a period of one (1) year.
(2) A person may request an administrative hearing pursuant to KRS Chapter 13B if the person’s falconry permit is:
(a) Denied; or
(b) Revoked.

Section 11. Incorporation by Reference. (1) The following material is incorporated by reference:
(c) “Falconry Take Location Report”, January 2013 edition; and

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Fish and Wildlife Resources, #1 Sportsman’s Lane, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. Eastern Time. KRS 150.025 authorizes the department to promulgate administrative regulations governing the taking of wildlife. 50 C.F.R., Parts 13, 17, 21, and 22 authorize the protection of endangered species and birds of prey. This administrative regulation establishes the requirements for the propagation of raptors and falconry purposes.

Section 1. Definitions. (1) “Exotic raptor” means those species which have no subspecies occurring in the wild in the United States or Mexico and which require the holding of a joint state and federal falconry permit to lawfully possess.
(2) “Legal hunting raptor” means the great horned owl (Bubo virginianus) and all hawks and falcons of the genera Falco, Accipiter, and Buteo, including those that are endangered or threatened and under conditions described in Section 4(1)(c) of this administrative regulation, golden eagles (Aquila chrysaetos) as well as threatened species.

Section 2. Except as provided by Sections 3 through 11 of this administrative regulation, C.F.R., Part 13, General Permit Procedures; Part 17, Subpart 17.11, Endangered and Threatened Wildlife; Part 21, Migratory Bird Permits; and Part 22, Eagle Permits shall apply to the propagation of raptors and falconry purposes.

Section 3. Hunting Licenses, Falconry Permit Requirements and Transportation Permit Waiver. (1) Wildlife may be taken within aggregate harvest limits with any legal hunting raptor provided the falconer has a valid state or federal falconry permit and valid Kentucky resident or nonresident hunting license in his or her possession.
(2) A licensed falconer may undertake intrastate transportation of any legally held raptor without possessing a transportation permit as required in 301 KAR 2:081 and 2:082.

(a) Apprentice falconry permits.
(1) An apprentice falconer shall be at least fourteen (14) years of age and shall have a sponsor holding a general or master falconry permit.
(2) An applicant between the ages of fourteen (14) and sixteen (16) years shall provide a written consent form or letter from a parent or guardian.
(3) An apprentice may take and possess only one (1) nonexotic raptor, which shall be taken from the wild, and shall not take more than one (1) replacement from the wild during any twelve (12) month period which begins when the first replacement raptor is taken from the wild.
(a) Only an American kestrel (Falco sparverius), red tailed hawks (Buteo Jamaicensis), red-shouldered hawks (Buteo Lineatus), or any exotic legal hunting raptor may be possessed or taken by an apprentice falconer.
(4) The red tailed and red-shouldered hawks shall be first year (passage) age class birds, capable of flight.
(5) Any American kestrel which has left the nest and is capable of flight may be taken from the wild.
(6) There shall be no age restriction on exotic raptors.
(b) General falconry permits.
(1) A general-permittee shall be:
(a) At least eighteen (18) years of age;
(b) Have at least two (2) years experience in the practice of falconry at the apprentice level; and
(c) Have complied with all reporting requirements of this administrative regulation.
(2) A permittee at the general level may possess no more than two (2) nonexotic raptors and shall not take more than two (2) replacements from the wild during any twelve (12) month period which begins when any replacement raptor is taken from the wild.
(3) A general permittee may take and possess any legal hunting raptor defined in this administrative regulation.
(c) Master falconry permits.
(1) A master permittee shall have at least five (5) years experience in the practice of falconry at the general class level and have complied with all requirements of this administrative regulation.
(2) A master permittee may possess no more than three (3) nonexotic raptors.
(3) No more than two (2) raptors for replacement birds shall be taken from the wild during any twelve (12) month period which begins when any replacement raptor is taken from the wild.
(4) A master permittee may take and possess any legal hunting raptor, but shall not take, in any twelve (12) month period, as part of the three (3) bird limitation, more than one (1) raptor listed as threatened in 50 C.F.R., Part 17, Subpart B, Section 17.11, and then only when approved by the U.S. Fish and Wildlife Service and the Department of Fish and Wildlife Resources.
(5) A master falconer may replace any number of captive bred raptors a year if the possession limit at one (1) time is not exceeded.
(6) If a permit has been issued by the department and in accordance with the Bald and Eagle Protection Act and 50 C.F.R., Part 22, Subpart B, Section 22.24, a master permittee may take and possess golden eagles for falconry purposes.
(7) A master permittee shall not take any species listed as endangered by 50 C.F.R., Part 17, Subpart B, Section 17.11, but may possess those species in accordance with the Endangered Species Act and implementing regulations.
(d) Applicability of Limits.
(1) Sponsors.
(a) A sponsor shall hold a master or general falconry permit.
(b) A sponsor shall not have more than three (3) apprentices at any one (1) time.
(c) A sponsor withdrawing sponsorship shall notify the department in writing giving reasons for withdrawal and shall notify the apprentice.
(d) If the apprentice does not have a new sponsor within thirty (30) days from the date of notification of withdrawal, his or her permit shall be deemed cancelled and the birds relocated.
(2) Application, processing and issuance.
(a) In order to obtain any class of joint state/federal falconry permit, an applicant shall complete the standard falconry permit application form (KYF-1), incorporated by reference in Section 12...
of this administrative regulation, as designated by the Department of Fish and Wildlife Resources and approved by the U.S. Fish and Wildlife Service.

(b) Accompanying the completed application shall be two (2) checks:

1. One (1) payable to the Department of Fish and Wildlife Resources in the amount specified for a falconry permit in 301 KAR 2:082, and

2. One (1) payable to the U.S. Fish and Wildlife Service in the amount specified in 50 C.F.R. Part 13, Subpart B, Section 13.11.

(c) Also accompanying the application shall be an inventory of raptors which the applicant possesses at the time of application as specified in Section 6(1) of this administrative regulation and 50 C.F.R. Part 21, Subpart C, Section 21.28.

(d) Upon receipt of a completed application, inventory and fees, the application shall be forwarded to the appropriate state conservation officer who shall administer the required examination and inspect equipment and facilities.

(e) If the equipment and facilities are found to be adequate and the applicant passes the examination as specified in subsection (4) of this section, the state conservation officer shall certify that by affixing his signature on a letter of recommendation, and the Department of Fish and Wildlife Resources shall forward the application, certification, appropriate fee and test score to the U.S. Fish and Wildlife Service.

If the U.S. Fish and Wildlife Service may then issue the permit according to the applicable terms and conditions of 50 C.F.R. Parts 13, 21 or 22.

(4) Examination required.

(a) An applicant for any class of falconry permit shall take an appropriate examination and score no less than eighty (80) percent.

(b) The test shall be approved in accordance with 50 C.F.R. Subpart C, Part 21.29(i) and shall be administered and supervised by the Department of Fish and Wildlife Resources at a designated site.

(c) Duration of permits: A permit shall be valid for a period of three (3) years from date of issuance.

(5) Fees. Falconry permit fees are as listed in 301 KAR 3:022.

Section 5. Facilities and Equipment (1) Facilities and equipment shall meet the minimum standards described in 50 C.F.R. Part 21, Subpart C, Section 21.29.

(2) Facilities, equipment, and raptors shall be made available at all times by authorized personnel of the Department of Fish and Wildlife Resources and the U.S. Fish and Wildlife Service.

Section 6. Marking. Any peregrine falcon (Falco peregrinus), gyrfalcon (Falco rusticolus) and Harris hawks (Parabuteo unicinctus) shall be banded with markers supplied by the U.S. Fish and Wildlife Service at all times according to provisions of 50 C.F.R. Part 21, Subpart C, Section 21.29.

Section 7. License Requirements and Conditions for Taking Raptors From the Wild.

(1) License requirements.

(a) A holder of a Kentucky falconry permit shall have in his or her possession a valid annual Kentucky hunting license before taking any raptor from the wild.

(b) Before taking a raptor from the wild, a nonresident shall have a Kentucky, nonresident, annual hunting license and shall state/federal permit or individual state and federal falconry permit from his or her home state and a special permit from the Department of Fish and Wildlife Resources.

(c) Application for a special permit shall be made by writing the Department of Fish and Wildlife Resources, #1 Sportsman’s Lane, Frankfort, Kentucky 40601, at least fifteen (15) days in advance of the date on which the permit is desired, and describing the nature of the request, the applicant’s name, address, and the status and number of the federal/state falconry permit.

(2) Conditions for taking raptors from the wild.

(a) Evas.

1. A young bird not yet capable of flight (eyes) may be taken only by a general or master falconer and only during the period May 12 through July 14.

2. No more than two (2) eyas shall be taken from the wild by the same permittee during this period.

3. At least one (1) young shall be left in any nest from which raptors are taken.

(b) Passage birds. A first year (passage) bird may be taken only during the period September 7 through December 31.

(c) Retrapping. A raptor may be retrapped only in accordance with 50 C.F.R. Part 21, Subpart C, Section 21.29.

(d) Mature birds.

1. Only the American kestrel and the great horned owl may be taken when-over one (1) year old, except that any legal hunting raptor taken under a depredation or special purpose permit may be used for falconry by general and master falconers.

2. A trap or other device for taking raptors alive shall be tagged with the owner’s name and address.

(e) A raptor taken from the wild shall be reported to the U.S. Fish and Wildlife Service as required in 50 C.F.R. Part 21, Subpart C, Sections 21.28, 21.29, and 21.30 with a copy of the report being sent to the Department of Fish and Wildlife Resources at the same time.

Section 8. Raptors Acquired Before 1977. (1) A person possessing a raptor legally acquired before January 1, 1977, and who fails to meet the permit requirements, shall be allowed to retain the raptor with a nonhunting permit.

(b) These raptors shall not be replaced nor used for hunting.

(c) Facilities and equipment for holding them shall meet the standards in Section 5 of this administrative regulation.

(2) A falconry permittee legally possessing raptors acquired before January 1, 1977, in excess of the number allowed under his class permit, shall be allowed to retain and hunt the extra raptors. Replacement of those raptors shall not occur, nor shall any additional nonexotic raptor be obtained, until the number in possession is at least one (1) less than the total number authorized by the class of permit held by the permittee.

Section 9. Importation, Trading or Transferring, Purchasing, Bartering or Selling, Temporary Care and Feathers of Raptors.

Importation. A holder of a valid falconry permit may transport any legally held raptor into or within the State of Kentucky without a transportation permit from the Department of Fish and Wildlife Resources as required in 301 KAR 2:081 and 2:082.

(2) Trading or transferring.

(a) Any class falconry permittee may trade or transfer a raptor to another permittee if the transaction occurs entirely within the state of Kentucky and no other consideration is involved.

(b) A permittee may trade or transfer a raptor to another permittee in an interstate transaction if the prior written approval of all states involved is obtained and no money or other consideration is involved in the transaction, except as allowed in 50 C.F.R. Part 21.

Subpart C, Section 21.28(i)(3).

(c) This transaction shall be reported to the U.S. Fish and Wildlife Service as required in 50 C.F.R. Part 21, Subpart C, Sections 21.28 and 21.30 with a copy of the report being sent to the Department of Fish and Wildlife Resources at the same time.

(3) Purchasing, bartering or selling. General and master class permittees may purchase, barter or sell any lawfully possessed raptor which is bred in captivity under authority of a raptor propagation permit issued pursuant to 50 C.F.R. Part 21, Subpart C, Sections 21.28 and 21.30, subject to the following conditions:

(b) Any permittee subject to the foregoing conditions with any person in the United States or a foreign country shall meet the conditions specified in 50 C.F.R. Part 21, Subpart C, Section 21.304(5).

(b) A raptor propagation permittee who sells or barter raptors shall have a commercial captive wildlife permit issued by the Department of Fish and Wildlife Resources according to provisions of 301 KAR 2:081.

(c) All transactions shall be reported to the U.S. Fish and Wildlife Service as required in 50 C.F.R. Part 21, Subpart C, Sections 21.28 and 21.30 with a copy of the report being sent to the Department of Fish and Wildlife Resources at the same time.

(4) Temporary relocation of raptors. A raptor may be temporari-
Section 10. Release of Raptors. (1) A person shall not intentionally release to the wild any species not native to Kentucky without first obtaining written permission from the commissioner.

(2) The mark from the released bird shall be removed and surrendered to the department.

(3) The mark from an intentionally released indigenous bird shall also be removed and surrendered to the department.

(4) A federal bird band shall be affixed to a captive bred raptor intentionally released to the wild.


(a) A person shall not breed or propagate raptors without obtaining the appropriate Kentucky captive wildlife permit as required in 301 KAR 2:08.

(b) A commercial captive wildlife permit authorizes the propagation and sale of raptors.

(c) A non-commercial captive wildlife permit authorizes only propagation.

(d) A permittee shall comply with all requirements, including permit application of 50 C.F.R. Part 21, Subpart C, Section 21.30.

(2) Authorized activities. All activities permitted by 50 C.F.R. Part 21, Subpart C, Section 21.30 are authorized in Kentucky except as otherwise noted in this administrative regulation.

(3) Applications, records, and reports. A copy of all raptor propagation applications, records, and reports required by the U.S. Fish and Wildlife Service in 50 C.F.R. Part 21, Subpart C, Section 21.30, shall be submitted to the Department of Fish and Wildlife Resources on the same dates as required by 50 C.F.R. Part 21, Subpart C, Section 21.30.

Section 12. Incorporation by Reference. (1) Standard falconry permit application form (KYF-1). (12/6/06) is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright laws, at the Kentucky Department of Fish and Wildlife, #1 Sportsman’s Lane, Frankfort, Kentucky 40601, phone (502) 564-3400, fax (502) 564-9136, email tfpubliccomments@ky.gov.

BENLY KINMAN, Deputy Commissioner
For DR. JONATHAN GASSETT, Commissioner
MARCHETA SPARROW, Secretary
APPROVED BY AGENCY: December 5, 2012
FILED WITH LRC: December 28, 2012 at 8 a.m.
CONTACT PERSON: Rose Mack, Department of Fish and Wildlife Resources, Arnold L. Mitchell Building, #1 Sportsman’s Lane, Frankfort, Kentucky 40601, phone (502) 564-3400, fax (502) 564-9136, email tfpubliccomments@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Rose Mack

(1) Provide a brief summary of:

(a) What the administrative regulation does: This administrative regulation establishes permitting, taking, possessing, and reporting requirements for people engaged in falconry and raptor propagation.

(b) The necessity of the administrative regulation: This administrative regulation is necessary to manage and conserve raptors and to provide reasonable opportunities for sport and recreation. This regulation is also necessary to comply with federal regulation requirements.

(c) How does this administrative regulation conform to the authorizing statutes: KRS 150.025(1) authorizes the department to promulgate administrative regulations establishing open seasons for the taking of wildlife, bag limits, and methods of taking wildlife, and to make these requirements apply to a limited area. KRS 150.280(1) requires the department to promulgate administrative regulations establishing procedures for propagating and holding of protected wildlife. 50 C.F.R. Parts 13, 17, 21, and 22 establish requirements for permitting, taking, possessing, and selling of raptors and endangered and threatened species.

(d) How will this administrative regulation assist in the effective administration of the statutes: By establishing guidelines on raptor propagation and falconry, this administrative regulation ensures the protection of birds of prey in compliance with 50 C.F.R. Parts 13, 17, 21, 22.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change the existing administrative regulation: The state will now solely oversee the permitting of individuals wishing to propagate raptors or practice falconry.

(b) The necessity of the amendment to this administrative regulation: The U.S. Fish and Wildlife Service is requiring all states to assume the responsibility for oversight of raptor propagation and falconry.

(c) How does the amendment conform to the authorizing statutes: See “C” above.

(d) How the amendment will assist in the effective administration of the statutes: See “D” above.

(3) List the type and number of individuals, businesses, organizations or state and local governments that will be affected: This regulation will affect falconers and captive wildlife permittees who hold raptors in Kentucky as well as nonresidents wishing to obtain a raptor within the state for falconry. There are approximately 57 falconry permittees and about 10 captive wildlife permittees in Kentucky. The number of nonresidents wishing to obtain a raptor varies from year to year but generally stays under 20 per year.

(4) Provide an analysis of how the entities identified in question (3) may be impacted by either the implementation of this administrative regulation, if new of by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Individuals seeking renewal will submit a completed application, remit the appropriate fee, and provide a completed, signed copy of the raptor facility and equipment inspection form. Those individuals seeking to obtain a falconry permit for the first time will be required to take an exam and receive a passing mark (minimum score 80 per cent), along with submitting their application, raptor facility and equipment inspection form, fee and supporting materials. Nonresidents wishing to obtain a raptor will need a valid Kentucky nonresident hunting license, a valid falconry permit or equivalent from their home state, and an approved nonresident raptor take form from the Department. Note, these criteria are the same as the existing regulation, however the state will administer the exam rather than the USFWS.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): A Kentucky falconry permit costs $75, but this amendment will not require or create any new costs.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Individuals will have less waiting time since there will only be a State permit issued and historically the federal permit could take extended periods of time to obtain. Also, individuals will now only have to submit one fee. This will streamline the process for the user.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: Department costs to administer this administrative regulation will be offset by the permit fee.

(b) On a continuing basis: There will be no additional cost to the agency to implement this administrative regulation on a continuing basis.

(6) What is the source of funding to be used for implementation and enforcement of this administrative regulation: The source of funding is the State Game and Fish Fund.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. No increase in fees or funding will be necessary to implement this administrative
regulation.

(8) State whether or not this administrative regulation establishes any fees directly or indirectly increases any fees: This administrative regulation does not establish any fees directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not used because this administrative regulation applies equally to all falconers and raptor propagators.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department of Fish and Wildlife Resources’ Divisions of Wildlife and Law Enforcement will be impacted by this administrative regulation.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 150.025(1) authorizes the department to promulgate administrative regulations establishing open seasons for the taking of wildlife, bag limits, and methods of taking wildlife, and to make these requirements apply to a limited area. KRS 150.280(1) requires the department to promulgate administrative regulations establishing procedures for propagating and holding of protected wildlife. 50 C.F.R. Parts 13, 17, 21, and 22 establish requirements for permitting, taking, possessing, and selling of raptors and endangered and threatened species.

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The permit fee will generate approximately $5,000 for the department for the first year.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The permit fee will generate approximately $5,000 for the department for subsequent years.

(c) How much will it cost to administer this program for the first year? The cost to administer the program will be offset by permit revenue during the first year.

(d) How much will it cost to administer this program for subsequent years? The cost to administer the program will be offset by permit revenue in subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

FEDERAL MANDATE ANALYSIS COMPARISON


2. State compliance standards. The Department of Fish and Wildlife Resources is now required to set falconry requirements and seasons which are within the frameworks established by the U.S. Fish and Wildlife Service and published in 50 C.F.R. Parts 21 and 22.

3. Minimum or uniform standards contained in the federal mandate. 50 C.F.R. Parts 21 and 22 contain minimum federal standards governing falconry, including falconry possession limits, permit requirements, facilities and care standards, and reporting requirements.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? Yes.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The federal mandate defines the species and possession limits falconers are allowed for falconry purposes. States are permitted to be more restrictive, but not more liberal in their respective regulations. Kentucky will be more restrictive in the possession limits of certain raptor species that are of conservation concern in the state.

STATEMENT OF EMERGENCY

900 KAR 7:030E

This emergency administrative regulation is being promulgated to incorporate by reference new data reporting manuals for use by hospitals and ambulatory facilities when submitting administrative claims data to the Cabinet for Health and Family Services, Office of Health Policy. Changes to the data reporting manuals are necessary as a new payor code will be needed to identify claims billed to the new Medicaid Managed Care Organization serving region 3 when they become operational in January, 2013. The new payor code is necessary so that the most accurate data is available when analysis and reports are produced related to the cost, quality, and outcomes of health care services provided in the Commonwealth. The data reporting manuals also include changes to incorporate the 1) addition of the requirement to report newly created CPT/HCPCS codes, 2) new edits, and 3) a sample of new ad hoc report. An ordinary administrative regulation is not sufficient because the changes are necessary so that accurate data may be collected from the time of implementation of the Managed Care Organizations. Failure to enact this administrative regulation on an emergency basis will compromise the data necessary to provide data related to the cost, quality, and outcomes of health care services provided in the Commonwealth. This emergency administrative regulation shall be replaced by an ordinary administrative regulation that will be concurrently filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVE BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary
Cabinet for Health and Family Services
Office of Health Policy

(Emergency Amendment)

900 KAR 7:030E. Data reporting by health care providers.

RELATES TO: KRS Chapter 13B, 216.2920-216.2929

STATUTORY AUTHORITY: KRS 216.2923(3), 216.2925

EFFECTIVE: December 27, 2012

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216.2925 requires that the Cabinet for Health and Family Services promulgate administrative regulations requiring specified health care providers to provide the cabinet with data on cost, quality, and outcomes of health care services provided in the Commonwealth. KRS 216.2923(3) authorizes the cabinet to promulgate administrative regulations to impose fines for failure to report required data. This administrative regulation establishes the required data elements, forms, and timetables for submission of data to the cabinet and fines for noncompliance.

Section 1. Definitions. (1) "Agent" means any entity with which the cabinet may contract to carry out its statutory mandates, and which it may designate to act on behalf of the cabinet to collect, edit, or analyze data from providers.

(2) "Ambulatory facility" is defined by KRS 216.2920(1).

(3) "Cabinet" is defined by KRS 216.2920(2).

(4) "Coding and transmission specifications", "Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals", or "Kentucky Data Coordinator's Manual for Ambulatory Facilities" means the document containing the technical directives the cabinet issues concerning technical matters subject to frequent change, including codes and data for uniform provider entry into particular character positions and fields of the standard billing form and uniform provider formatting of fields and character positions for purposes of electronic data transmissions.
"Hospital" is defined by KRS 216.2920(6).

"Hospitalization" means the inpatient medical episode identified by a patient's admission date, length of stay, and discharge date, that is identified by a provider-assigned patient control number unique to the patient episode, except for:

(a) Inpatient services a hospital may provide in swing, nursing facility, skilled, intermediate or personal care beds; or
(b) Hospice care.

"National Provider Identifier" or "NPI" means the unique identifier assigned by the Centers for Medicare and Medicaid Services to an individual or entity that provides health care services and supplies.

"Outpatient services" means services performed on an outpatient basis in a hospital in accordance with Section 3(2) of this administrative regulation or services performed on an outpatient basis by an ambulatory facility in accordance with Section 4 of this administrative regulation.

"Provider" means a hospital, ambulatory facility, clinic, or other entity of any nature providing hospitalizations, mammograms, or outpatient services as defined in the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals or the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

"Record" means the documentation of a hospitalization or outpatient service in the format prescribed by the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals or the Kentucky Data Coordinator's Manual for Ambulatory Facilities as approved by the Statewide Data Advisory Committee on a computer readable electronic medium.

"Standard Billing Form" means the uniform health insurance claim form pursuant to KRS 304.14-135, the Professional 837 (ASC X12N 837) format, the Institutional 837 (ASC X12N 837) format, or its successor as adopted by the Centers for Medicare and Medicaid Services, or the HCFA 1500 for use by hospitals and other providers in billing for hospitalizations and outpatient services.

Section 2. Medicare Provider-Based Entity. A licensed outpatient facility that is a Medicare provider-based entity of a hospital and reports under the hospital's provider number shall be separately identifiable through a facility-specific NPI.

Section 3. Data Collection for Hospitals. (1) Inpatient Hospitalization records. Hospitals shall document every hospitalization they provide on a Standard Billing Form and shall, from every record, copy and provide to the cabinet the data specified in Section 13 of this administrative regulation.

(2) Outpatient services records.

(a) Hospitals shall document on a Standard Billing Form the outpatient services they provide and shall from every record, copy and provide to the cabinet the data specified in Section 13 of this administrative regulation.

(b) Hospitals shall submit records that contain the required outpatient services procedure codes specified in the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals.

(3) Data collection on patients. Hospitals shall submit required data on every patient as provided in Section 13 of this administrative regulation, regardless of the patient's billing or payment status.

Section 4. Data Collection for Ambulatory Facilities. (1) Outpatient Services Records.

(a) Ambulatory facilities shall document on a Standard Billing Form the outpatient services they provide and shall, from every record, copy and provide to the cabinet the data specified in Section 14 of this administrative regulation.

(b) Ambulatory facilities shall submit records that contain the required outpatient services procedure codes specified in the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

(2) Data collection on patients. Ambulatory facilities shall submit required data on every patient as provided in Section 14 of this administrative regulation, regardless of the patient's billing or payment status.

Section 5. Data Finalization and Submission by Providers. (1) Submission of final data.

(a) Data shall be final for purposes of submission to the cabinet as soon as a record is sufficiently final that the provider could submit it to a payor for billing purposes, regardless of whether the record has actually been submitted to a payor.

(b) Finalized data shall not be withheld from submission to the cabinet on grounds that it remains subject to adjudication by a payor.

(c) Data on hospitalizations shall not be submitted to the cabinet before a patient is discharged and before the record is sufficiently final that it could be used for billing.

(2) Data submission responsibility.

(a) If a patient is served by a mobile health service, specialized medical technology service, or another situation where one (1) provider provides services under contract or other arrangement with another provider, responsibility for providing the specified data to the cabinet shall reside with the provider that bills for the service or would do so if a service is unbilled.

(b) Charges for physician services provided within a hospital shall be reported to the cabinet.

1. Responsibility for reporting the physician charge data shall rest with the hospital if the physician is an employee of the hospital.

2. A physician charge contained within a record generated by a hospital shall be clearly identified in a separate field within the record so that the cabinet may ensure comparability when aggregating data with other hospital records that do not contain physician charges.

(3) Transmission of records.

(a) Records submitted to the cabinet by hospitals shall be uniformly completed and formatted according to coding and transmission specifications set forth by the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals.

(b) Records submitted to the cabinet by ambulatory facilities shall be uniformly completed and formatted according to coding and transmission specifications set forth by the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

(c) All providers shall submit records on computer-readable electronic media.

(d) Providers shall provide back-up securely against accidental erasure or loss of the data until all incomplete or inaccurate records identified by the cabinet have been corrected and resubmitted.

(4) Verification and audit trail for electronic data submissions.

(a) Each provider shall maintain a date log of data submissions and the number of records contained in each submission, and shall make the log available for inspection upon request by the cabinet.

(b) The cabinet shall, within twenty-four (24) hours of submission, verify by electronic message to each provider the receipt of the provider's data transmissions and the number of records in each transmission.

(c) A provider shall immediately notify the cabinet of a discrepancy between the provider's data log and a verification notice.

Section 6. Data Submission Timetable for Providers. (1) Quarterly submissions. Providers shall submit data at least once for each calendar quarter. A quarterly submission shall:

(a) Contain data, which during that quarter became final as specified in Section 5(1) of this administrative regulation; and

(b) Be submitted to the cabinet not later than forty-five (45) days after the last day of the quarter.

1. If the 45th day falls on a weekend or holiday, the submission due date shall be the next working day.

2. Calendar quarters shall be January 1 through March 31, April 1 through June 30, July 1 through September 30, and October 1 through December 31.

(2) Submissions more frequent than quarterly. Providers may submit data after records become final as specified in Section 5(1) of this administrative regulation and at a reasonable frequency convenient to a provider for accumulating and submitting batch data.

Section 7. Data Corrections for Hospitals. (1) Editing. Data received by the cabinet shall, upon receipt, be edited to ensure completeness and validity of the data. Computer editing routines
shall identify for correction every record in which the submitted contents of required fields are not consistent with the cabinet’s coding and transmission specifications contained in the Kentucky Inpatient and Outpatient Data Coordinator’s Manual for Hospitals.

Time permitted for corrections. The cabinet shall allow providers thirty (30) days in which to submit corrected copies of initially submitted data the cabinet identifies as incomplete or invalid as a result of edits.

(a) The thirty (30) days shall begin on the date of the cabinet’s notice informing the provider that corrections are required.

(b) Providers shall submit corrected data by electronic transmission or postmarked mailing within thirty (30) days.

(c) Corrected data submitted to the cabinet shall be uniformly completed and formatted according to the cabinet’s coding and transmission specifications contained in the Kentucky Inpatient and Outpatient Data Coordinator’s Manual for Hospitals.

(3) Percentage error rate.

(a) When editing data upon its initial submission, the cabinet shall identify and return to the provider for correction every record in which one (1) or more of the required data elements fails to pass the edit.

(b) When editing data that a provider has submitted, the cabinet shall check for an error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.

(c) The cabinet may return for further correction any submission of allegedly corrected data in which the provider fails to achieve a corrected error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.

(d) For the first data submission, the cabinet shall not count as errors any data for patients admitted prior to thirty (30) days of the effective date of this administrative regulation.

Section 8. Data Corrections for Ambulatory Facilities. (1) Editing. Data received by the cabinet shall, upon receipt, be edited to ensure completeness and validity of the data. Computer editing routines shall identify for correction every record in which the submitted contents of required fields are not consistent with the cabinet’s coding and transmission specifications contained in the Kentucky Data Coordinator’s Manual for Ambulatory Facilities.

(2) Time permitted for corrections. The cabinet shall allow providers thirty (30) days in which to submit corrected copies of initially submitted data the cabinet identifies as incomplete or invalid as a result of edits.

(a) The thirty (30) days shall begin on the date of the cabinet’s notice informing the provider that corrections are required.

(b) Providers shall submit corrected data by electronic transmission or postmarked mailing within thirty (30) days.

(c) Corrected data submitted to the cabinet shall be uniformly completed and formatted according to the cabinet’s coding and transmission specifications contained in the Kentucky Data Coordinator’s Manual for Ambulatory Facilities.

(d) The cabinet shall grant a provider an extension of time to submit corrections, if the provider has formally informed the cabinet of significant problems in performing the corrections and has formally requested, in writing, an extension of time beyond the thirty (30) day limit.

(3) Percentage error rate.

(a) When editing data upon its initial submission, the cabinet shall identify and return to the provider for correction every record in which one (1) or more of the required data elements fails to pass the edit.

(b) When editing data that a provider has submitted, the cabinet shall verify an error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.

(c) The cabinet may return for further correction any submission of allegedly corrected data in which the provider fails to achieve a corrected error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.

Section 9. Fines for Noncompliance for Providers. (1) A provider failing to meet quarterly submission guidelines as established in Sections 6, 7, and 8 of this administrative regulation shall be assessed a fine of $500 per violation.

(2) The cabinet shall notify a noncompliant provider by certified mail, return receipt requested, of the documentation of the reporting deficiency and the assessment of the fine.

(3) A provider shall have thirty (30) days from the date of receipt of the notification letter to pay the fine which shall be made payable to the Kentucky State Treasurer and sent by certified mail to the Kentucky Cabinet for Health and Family Services, Office of Health Policy, 275 East Main Street 4 W-E, Frankfort, Kentucky 40621.

(4) Fines during a calendar year shall not exceed $1,500 per provider.

Section 10. Extension or Waiver of Data Submission Timeframes. (1) Providers experiencing extenuating circumstances or hardships may request from the cabinet, in writing, a data submission extension or waiver.

(a) Providers shall request an extension or waiver from the Office of Health Policy on or before the last day of the data reporting period to receive an extension or waiver for that period.

(b) Extensions and waivers shall not exceed a continuous period of greater than six (6) months.

(2) The cabinet shall consider the following criteria in determining whether to grant an extension or waiver:

(a) Whether the request was made due to an event beyond the provider’s control, such as a natural disaster, catastrophic event, or theft of necessary equipment or information;

(b) The severity of the event prompting the request; and

(c) Whether the provider continues to gather and submit the information necessary for billing.

(3) A provider shall not apply for more than three (3) extensions or waivers during a calendar year.

Section 11. Appeals for Providers. (1) A provider notified of its noncompliance and assessed a fine pursuant to Section 9(1) of this administrative regulation shall have the right to appeal within thirty (30) days of the date of the notification letter.

(a) If the provider believes the action by the cabinet is unfair, without reason, or unwarranted, and the provider wishes to appeal, it shall appeal in writing to the Secretary of the Cabinet for Health and Family Services, 5th Floor, 275 East Main Street, Frankfort, Kentucky 40621.

(b) Appeals shall be filed in accordance with KRS Chapter 13B.

(2) Upon receipt of the appeal, the secretary or designee shall issue a notice of hearing no later than twenty (20) days before the date of the hearing. The notice of the hearing shall comply with KRS 13B.050. The secretary shall appoint a hearing officer to conduct the hearing in accordance with KRS Chapter 13B.

(3) The hearing officer shall issue a recommendation in accordance with KRS 13B.110. Upon receipt of the recommended order, following consideration of any exceptions filed pursuant to KRS 13B.110(4), the secretary shall enter a final decision pursuant to KRS 13B.120.

Section 12. Working Contacts for Providers. (1) By January 1 of each calendar year, a provider shall report by letter to the cabinet the names and telephone numbers of a designated contact person and one (1) back-up person to facilitate technical follow-up in data reporting and submission.

(a) A provider’s designated contact and back-up shall not be the chief executive officer unless no other person employed by the provider has the requisite technical expertise.

(b) The designated contact shall be the person responsible for review of the provider’s data for accuracy prior to the publication by the cabinet.

(2) If the chief executive officer, designated contact person, or back-up person changes during the year, the name of the replacing person shall be reported immediately to the cabinet.

Section 13. Required Data Elements for Hospitals. (1) Hospitals shall ensure that each record submitted to the cabinet contains
at least the data elements identified in this section and as provided on the Standard Billing Form.  

(2) Asterisks identify elements that shall not be blank and shall contain data or a code as specified in the cabinet's coding and transmission specifications contained in the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals. 

(3) Additional data elements, as specified in the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals, shall be required by the cabinet to facilitate proper collection and identification of data. 

This section is incorporated by reference. (1) The following material is incorporated by reference:  
(a) "Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals," revised January 1, 2013, April 30, 2012; and  

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law at the Cabinet for Health and Family Services, 275 East Main Street 4WE, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. 

This is to certify that the Executive Director of the Office of Health Policy has reviewed and recommended this administrative regulation prior to its adoption, as required by KRS 156.070(4). 

ERIC FRIEDLANDER, Acting Executive Director 
AUDREY TAYSE HAYNES, Secretary 
APPROVED BY AGENCY: December 21, 2012 
FILED WITH LRC: December 27, 2012 at 4 p.m. 
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40621, phone (502) 564-7905, fax (502) 564-7573. 

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Diona Mullins or Chandra Venettozzi 
1. Provide a brief summary of:  
(a) What this administrative regulation does: This administrative regulation provides clarification and instruction to specified health care providers on the process necessary to submit copies of administrative claims data to the Cabinet.
(b) The necessity of this administrative regulation: This administrative regulation is necessary so that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data. The administrative regulation contains the updated data submission manuals for both hospitals and ambulatory facilities. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider for region 3 – Humana Medicaid Managed Care. Additionally changes were made to incorporate the 1) addition of the requirement to report newly created CPT/HCPCS codes, 2) new edits, and 3) a sample of new ad hoc report.

(d) How this administrative regulation currently assists or will assist in achieving the purpose of the authorizing statutes: This administrative regulation is necessary so that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data to enable the Cabinet to publish the data and reports as required by 216.2925.

(d) How this administrative regulation currently assists or will assist in achieving the purpose of the authorizing statutes: This administrative regulation provides detailed instructions to specified health care providers relating to the data elements, forms and timetables necessary to comply with this administrative regulation. Provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This administrative regulation incorporates by reference updated data reporting manuals. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider for region 3 – Humana Medicaid Managed Care. Additionally changes were made to incorporate the 1) addition of the requirement to report newly created CPT/HCPCS codes, 2) new edits, and 3) a sample of new ad hoc report.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to provide new data submission manuals to facilities that submit data so that accuracy of the data is ensured.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment continues to conform to the content of the authorizing statutes by providing a standardized method of reporting by facilities.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the statutes as it provides detailed instructions on how to submit required data elements.

3. List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation will affect approximately 85 hospitals and ambulatory facilities that submit data to the Cabinet.

4. Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Each entity will collect and submit data as required. Entities are already required to submit data, this regulation incorporated by reference manuals that were revised due to the addition of one new payor code to identify a new Medicaid MCO provider for region 3 – Humana Medicaid Managed Care. Additionally changes were made to incorporate the 1) addition of the requirement to report newly created CPT/HCPCS codes, 2) new edits, and 3) a sample of new ad hoc report.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Each entity will collect and submit data as required. Entities are already required to submit data, this regulation incorporated by reference manuals that were revised to provide detailed submission requirements. Therefore, no additional cost will be incurred.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Data integrity is improved as all applicable payor codes are now included it the manuals and instructions have been provided related to the 1) addition of the requirement to report newly created CPT/HCPCS codes, 2) new edits, and 3) a sample of new ad hoc report.

5. Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: No additional costs will be incurred to implement this administrative regulation as the Office of Health Policy currently collects data and has the necessary data collection system in place.

(b) On a continuing basis: No additional costs will be incurred.

6. What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The state’s funding to be used for the implementation and enforcement of this administrative regulation will be from Office of Health Policy’s existing budget. No new funding will be needed to implement the provisions of this regulation.

7. Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is needed.

8. State whether or not this administrative regulation establishes any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees and does not increase any fees either directly or indirectly.

9. TIERING: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This administrative regulation affects the Office of Health Policy within the Cabinet for Health and Family Services.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 216.2920-216.2929.

(3) Identify the fiscal note on state or local government that requires or authorizes the action taken by the administrative regulation on a continuing basis.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is in effect? This administrative regulation will not generate any revenue.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will not generate any revenue.

(c) How much will it cost to administer this program for the first year? No additional costs will be incurred to implement this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? No additional costs will be incurred to implement this administrative regulation.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

STATEMENT OF EMERGENCY
902 KAR 55:015E

Under existing state law, certain formulations of synthetic cannabinoids are illegal. However, new variants of these drugs, currently promoted as a legal alternative to marijuana, have appeared on the street market. Therefore, this emergency administrative regulation is being amended to classify substances which are substantially similar to synthetic cannabinoids as Schedule I controlled substances, thereby effectuating a complete ban on these types of products. This action must be taken on an emergency basis in
VOLUME 39, NUMBER 8 – FEBRUARY 1, 2013

accordance with KRS 13A.190(1)(a) to address the growing threat of synthetic cannabinoids to the health, safety, and welfare of Kentucky’s citizens. Failure to enact this administrative regulation on an emergency basis in accordance with KRS 13A.190(1)(a) will compromise the state’s ability to act quickly in its efforts to address the growing use of unregulated synthetic cannabinoids, which are from three to over 100 times more potent than THC, the active ingredient found in marijuana. This emergency administrative regulation shall be replaced by an ordinary administrative regulation to be concurrently filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEFAN L. BESTHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Office of Inspector General
Division of Audits and Investigations
(Emergency Amendment)


RELATES TO: KRS 218A.010-218A.050, 21 C.F.R. 1308.11
STATUTORY AUTHORITY: KRS 194.050, 218A.020, 218A.040, 218A.250
EFFECTIVE: December 19, 2012
NECESSITY, FUNCTION, AND CONFORMITY: KRS 218A.020 authorizes the Cabinet for Health and Family Services[Human Resources] to add substances to or delete or reschedule substances enumerated in KRS Chapter 218A. After considering the criteria set forth in KRS 218A.020 and 218A.040 and applicable federal regulations, the Cabinet for Health and Family Services[Human Resources] designates the substances set forth in this administrative regulation as Schedule I controlled substances. This administrative regulation differs from the federal regulation because it designates substances that are substantially similar to synthetic cannabinoids as Schedule I controlled substances. The Cabinet for Health and Family Services recognizes that synthetic cannabinoids have significant abuse potential and inclusion on Kentucky’s Schedule I list will help reduce the risk to public health.

Section 1. Opiates. The Cabinet for Health and Family Services[Human Resources] hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any of the following opiates, including their isomers, optical isomers, esters, ethers, salts, salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, salts, and salts of isomers is possible within the specific chemical designation:

(1) Alphachymethadol (except Levo-alphachymethadol LAAM);
(2) Acetyl-alpha-methylfentanyl, N-1-(1-methyl-2-phenethyl)-4-piperidinyl-N-phenylacetamide;
(3) Alpha-methylfentanyl, N-1-alpha-methyl-beta-phenyl ethyl-4-piperidyl propionanilide, 1-(1-methyl-2-phenethyl)-4-(N-propanilido) piperidine;
(4) Alpha-methylthiofentanyl, N-1-methyl-2-(2-thiényl) ethyl-4-piperidinyl-N-phenylpropenamide;
(5) Benzylfentanyl, N-1-benzyl-4-piperidyl-N-phenylpropanamide;
(6) Beta-hydroxyfentanyl, N-1-(2-hydroxy-2-phenethyl)-4-piperidinyl-N-phenylpropenamide;
(7) Beta-hydroxy-3-methylfentanyl, N-1-(2-hydroxy-2-phenethyl)-3-methyl-4-piperidinyl-N-phenylpropenamide;
(8) Difenoxin;
(9) 3-Methylfentanyl, N-3-methyl-1-(2-phenethyl)-4-piperidyl-N-phenylpropenamide;
(10) 3-methylthiofentanyl N-3-methyl-1-(2-thiényl) ethyl-4-piperidinyl-N-phenylpropenamide;
(11) 1-methyl-4-phenyl-4-propionoxypiperidine (MPPP);
(12) Para-fluorofentanyl, (N-(4-fluorophenyl))-N-1-(2-phenethyl)-4-piperidinylpropanamide;
(13) 1-(2-phenethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);
(14) Thienylfentanyl, N-1-(2-thiényl) methyl-4-piperidyl-N-phenylpropanamide;
(15) Thiofentanyl N-phenyl-N-1-(2-thiényl)ethyl-4-piperidinylpropan-ame; and
(16) Tiilidine.

Section 2. Opium Derivatives. The Cabinet for Health and Family Services[Human Resources] hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any of the following opium derivatives, their salts, optical isomers, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, optical isomers, and salts of isomers is possible within the specific chemical designation:

(1) Drotebanol; and
(2) Etorphine (except hydrochloride salt).

Section 3. Hallucinogenic Substances. The Cabinet for Health and Family Services[Human Resources] hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any material, compound, mixture, or preparation which contains any quantity of the following hallucinogenic substances, their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this paragraph only, the term “isomer” includes the optical position and geometric isomer):

(1) alpha-ethyltryptamine (alpha-ethyl-1H-indole-3-ethanamine, 3-(2-aminoxyloxy)indole);
(2) 4-bromo-2, 5-dimethoxy-4-ethylamphetamine (4-bromo-2, 5- DMA, 4-bromo-2, 5-dimethoxy-alpha-ethylamphetamine);
(3) 2, 5-dimethoxyamphetamine (2, 5- DMA); (4) 2, 5-dimethoxy-4-ethylamphetamine (DOET);
(5) Ethylamine analog of phenylcyclohexylamine, cyclohexylamine, (1-phenylcyclohexyl) ethylamine, N-(1-phenylcyclohexyl) ethylamine, PCE);
(6) 3, 4-methylenedioxyamphetamine (MDMA);
(7) 4-methoxymethylphenylethylamine, paramethoxyamphetamine);
(8) 3, 4-methylenedioxy-N-ethylamphetamine (N-ethyl-alpha-methyl-3,4(methylenedioxy)phenethylamine, N-ethyl MDA, MDE, MDEA);
(9) N-hydroxy-3, 4-methylenedioxyamphetamine (N-hydroxy-alpha-methyl-3,4(methylenedioxy)phenethylamine, N-hydroxy MDA);
(10) Paraxyl (Synexyl, 3-Hexyl-1-hydroxy-7, 8, 9, 10- tetrahyro-6, 6, 9-trimethyl-6H-dibenzo b, d pyran);
(11) Pyrrolidine analog of phenylcyclohexylamine, (1-(1- phenylcyclohexyl)-pyrrolidine, PCP, PHP);
(12) Thiophene analog of phenylcyclohexylamine, (1-(1,2-thienyl)cyclohexyl)propanamide, (TCP, TPMP); and
(13) 1-(2-thienyl) cyclohexylpyrrolidine (TCPy).

Section 4. Depressants. The Cabinet for Health and Family Services[Human Resources] hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Mecloqualone; and
(2) Methaqualone.

Section 5. Stimulants. The Cabinet for Health and Family Services[Human Resources] hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:
(1) Aminorex (aminoxaphen, 2-amino-5-phenyl-2-oxazoline, 4,5-dihydro-5-phenyl-2-oxazolamline);
(2) Cathinone (2-amino-1-phenyl-1-propanone, alphaminopropiophenone, 2-aminopropiophenone, and norhedronedepisophen)
(3) cis-4-methylaminorex [(±) cis-4-methyl-4-aminomethyl-5-phenyl-2-oxazolamline];
(4) N,N-dimethylamphetetamine (N,N-alpha-trimethylbenzeneetha-namine), N,N-alpha-trimethylphenethylamine), its salts, optical isomers and salts of optical isomers;
(5) N-ethylamphetetamine;
(6) Fenethylline; anld
(7) Methcathinone (2-(methylamino)-propiophenone, alpha (methylamino)-propiophenone, alpha (methylamino)-propiophenone, 2-(methylamino)-1-phenylprop-1-one, alpha-N-methylaminopropiophenone, nonomethylpropiophen,ephedrine, N-methylcathinone, mephalythetamine, AL-464, AL-422, AL-463 and UR1431) its salts, optical isomers and salts of optical isomers.

Section 6. Synthetic Cannabinoids. The Cabinet for Health and
Family Services hereby designates as Schedule I controlled sub-
stances, in addition to those specified by KRS 218A.050, any sub-
stance, compound, mixture, or preparation which contains any
quantity of any synthetic cannabinoid and is not an FDA approved
drug, including the following:
(1) (1-pentyl-1H-indol-3-yl)(2,2,3,3-
tetramethylcyclopropyl)methanone (UR-144);
(2) (1-(2,5-fluoropentyl)deoxy-
(3) 2-(2,5-dimethylathoxy)phenyl-N-[2-
metoxophenyl]methyl)ethanamine (2,5H-NBOMe);
(4) 2-(4-iodo-2,5-dimethylathoxy)phenyl-
(5) 2-(4-bromo-2,5-dimethylathoxy)-phenyl-
(6) 2-(4-chloro-2,5-dimethylathoxy)phenyl-
MARY REINLE BEGLEY, Inspector General
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 12, 2012
FILED WITH LRC: December 19, 2012 at 9 a.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40621, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Mary Reine Begley, Stephanie Brammer-Barnes
(1) Provide a brief summary of:
(a) What this administrative regulation does: The substances
set forth in this administrative regulation are designated as Schedule I controlled substances.
(b) The necessity of this administrative regulation: This adminis-
trative regulation is necessary to comply with KRS 218A.020.
(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 218A.020 mandates that the Cabinet for Health and Family Services add, delete, or reschedule substances enumerated in the schedules set forth in KRS Chapter 218A. This administrative regulation designates Schedule I controlled substances.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by designating Schedule I controlled substances.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: Under existing state law, certain formulations of synthetic cannabinoids are illegal. However, new variants of these drugs have appeared on the market as a legal alternative to mari-
juana. This amendment classifies substances that are substantially similar to synthetic cannabinoids as Schedule I controlled sub-
stances, thereby effectuating a complete ban on these types of products.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to address the growing threat of synthetic cannabinoids to the health, safety, and welfare of Kentucky’s citizens. Additionally, this action is consistent with the National Association of State Controlled Substances Authori-
ties’ (NASCSA) October 2011 resolution encouraging the Drug Enforcement Administration and states to make synthetic canna-
biond Schedule I substances. A copy of NASCSA’s resolution may be downloaded at the following link: http://www.nascsa.org/Resolutions/res11.09.pdf.
(c) How the amendment conforms to the content of the authori-
zating statutes: This amendment conforms to the content of the authorizing statutes by designating substances that are subst-
entially similar to synthetic cannabinoids as Schedule I substances.
(d) How the amendment will assist in the effective administra-
tion of the statutes: This amendment will assist in the effective administration of the statutes by designating substances that are substantially similar to synthetic cannabinoids as Schedule I sub-
stances.
(3) List the type and number of individuals, businesses, organi-
zations, or state and local governments affected by this administra-
tive regulation: This regulation bans, from legal sale, chemical variations of synthetic cannabinoids that have been formulated as a legal alternative to marijuana. Since these products are sold at commercial retail shops, the ban imposed by this regulation would compel retailers to stop selling these substances and enable law enforcement to halt illegal sales.
(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Commercial retail shops that currently sell chemical variations of synthetic cannabinoids that have been formulated as a legal alternative to marijuana would be required to stop selling these products.
(b) In complying with this administrative regulation or amend-
ment, how much will it cost each of the entities identified in question (3): No additional costs will be incurred by retailers in order to comply with this amendment.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Compliance with this amendment will help address the growing threat of synthetic cannabinoids to the health, safety, and welfare of Kentucky’s citizens.
(5) Provide an estimate of how much it will cost the administra-
tive body to implement this administrative regulation:
(a) Initially: This administrative body will not incur additional costs to implement the changes made by this amendment.
(b) On a continuing basis: This administrative body will not incur additional costs to implement the changes made by this amendment.
(6) What is the source of the funding to be used for the imple-
mentation and enforcement of this administrative regulation: The source of funding to be used for the implementation and enforce-
ment of this administrative regulation will be agency funds.
(7) Provide a description of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding will be necessary to implement this amended ad-
ministrative regulation.
(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: The amendment to this administrative regulation will not establish or increase any fees.
(9) TIERING: Is tiering applied? Tiering is not applicable as compliance with this administrative regulation applies equally to all individuals or entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Local governments
will expend funds to arrest, prosecute, and incarcerate convicted defendants for trafficking, possessing, and manufacturing synthetic cannabinoids. Additionally, as these substances are new types of illegal drugs, there may be some additional cost in training law enforcement officers to recognize these drugs and deal with individuals under the influence. However, this regulation, in combination with existing law, will accomplish a total ban on these drugs before they get a foothold in Kentucky and thereby eradicate the problem of use and abuse.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 218A.020.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? There will be no additional revenue generated for state or local government for the first year that this administrative regulation is in effect.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? There will be no additional revenue generated for state or local government during subsequent years after this administrative regulation becomes effective.

   (c) How much will it cost to administer this program for the first year? There may be additional incarcerations related to this administrative regulation. While the expense of housing inmates may vary widely by jail, each additional inmate will increase facility costs by an estimated average of $31.34 per day.

   (d) How much will it cost to administer this program for subsequent years? There may be additional incarcerations related to this administrative regulation. While the expense of housing inmates may vary widely by jail, each additional inmate will increase facility costs by an estimated average of $31.34 per day.

   Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

   - Revenue (+/-):
   - Expenditures (+/-):
   - Other Explanation:

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 21 C.F.R. Section 1308.11 establishes the federal listing of Schedule I controlled substances.

2. State compliance standards. KRS 218A.020 permits the Cabinet for Health and Family Services to adopt a regulation to control a substance if it finds the substance has a potential for abuse.

3. Minimum or uniform standards contained in the federal mandate. The federal schedules of controlled substances are established in the federal mandate.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation adds substances that are substantially similar to synthetic cannabinoids to Kentucky’s list of Schedule I controlled substances. Synthetic cannabinoids are not listed on the federal listing of Schedule I controlled substances.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This amendment recognizes that synthetic cannabinoids have significant abuse potential and inclusion on Kentucky’s Schedule V list will help reduce the risk to public health.

STATEMENT OF EMERGENCY
907 KAR 1:711E

This emergency administrative regulation - which repeals 907 KAR 1:705 (Demonstration project: services provided through regional managed care partnerships [1115 Waiver]) and 907 KAR 1:710 [Managed behavioral health care initiative (1915b Waiver)] - is being promulgated concurrently with a new administrative regulation (907 KAR 17:010) which will establish managed care organization policies and requirements for Medicaid managed care in region three (3). Region three (3) encompasses Jefferson and fifteen (15) neighboring or nearby counties. 907 KAR 1:705 is being repealed because that version of managed care is authorized by an 1115 demonstration waiver (approved by the Centers for Medicare and Medicaid Services) that expires on December 31, 2022. Two (2) key differences between the demonstration waiver model and the new model is that the new model encompasses behavioral health services. Additionally, only one (1) entity provided managed care, under the demonstration waiver, and the Centers for Medicare and Medicaid Services (CMS) requires individuals to have a choice of managed care organizations (MCOs.) Consequently, DMS has contracted with four (4) entities — including the entity that has been performing managed care organization functions since the mid-1990s — to be responsible for managed care in region three (3) and the scope of managed care in region three (3) will now include behavioral health services. As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 1:705). Additionally, DMS is repealing 907 KAR 1:710 because it establishes policies and requirements for an obsolete managed care behavioral health program. This action must be implemented on an emergency basis to eliminate the presence of contradictory managed care organization requirements among Kentucky Medicaid regulations and to prevent a loss of federal funds. This emergency administrative regulation shall not be replaced by an ordinary administrative regulation as this emergency administrative regulation repeals 907 KAR 1:705 and 907 KAR 1:710 leaving nothing to be repealed by an ordinary administrative regulation. No ordinary administrative regulation is being promulgated.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office
(Emergency Repealer)

907 KAR 1:711E. Repeal of 907 KAR 1:705 and 907 KAR 1:710.

RELATES TO: 42 U.S.C. 1396a
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)
EFFECTIVE: December 21, 2012
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Kentucky Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation, in accordance with KRS 13A.310(3)(c), repeals 907 KAR 1:705 and 907 KAR 1:710. 907 KAR 1:705 is being repealed because the policies previously addressed in 907 KAR 1:705 are being addressed in four (4) other administrative regulations which are located in Chapter 17 of Title 907 of the Kentucky Administrative Regulations. 907 KAR 1:710 is being repealed because the subject addressed by it no longer exists.

Section 1. The following administrative regulations are hereby repealed:
(1) 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver); and
(2) 907 KAR 1:710, Managed behavioral health care initiative (1915b Waiver).

LAWRENCE KISSNER, Commissioner
REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation, in accordance with KRS 15A.0310(3)(c), repeals 907 KAR 17:005. Demonstration project: services provided through regional managed care partnerships (1115 Waiver); and 907 KAR 1:710, Managed behavioral care initiative (1915b waiver).

(b) The necessity of this administrative regulation: The administrative regulation is necessary to repeal 907 KAR 1:705 and 907 KAR 1:710. 907 KAR 1:705 is being repealed because that version of managed care [which applies to region three (3) of Kentucky] is authorized by an 1115 demonstration waiver (approved by the Centers for Medicare and Medicaid Services) that expires on December 31, 2012 and does not encompass behavioral health services. A new administrative regulation, 907 KAR 17:010 [Managed care organization requirements and policies relating to Medicaid managed care in region three (3)] that establishes managed care organization requirements and policies for region three (3) is being concurrently promulgated and operates under a different federal demonstration project: services provided through regional managed care partnerships (1115 Waiver). Additionally, it is necessary to repeal 907 KAR 1:705 and 907 KAR 1:710 to eliminate any potential contradiction in managed care policy stated in administrative regulation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by repealing obsolete or duplicate Medicaid program regulatory material as authorized by KRS 194A.030(2).

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by repealing obsolete or duplicate Medicaid program regulatory material as authorized by KRS 194A.030(2).

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is not an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is not an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is not an amendment to an existing administrative regulation.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This is not an amendment to an existing administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This repealer administrative regulation is not expected to affect individuals, businesses, organizations, or local government.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. No action is required of regulated entities.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3)? No cost is imposed on regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). No benefit, other than the elimination of potentially confusing archaic administrative regulation material, is expected for regulated entities.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The administrative regulation imposes no cost to the Department for Medicaid Services.

(b) On a continuing basis: The administrative regulation imposes no cost on the Department for Medicaid Services.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: No funding is necessary to implement the administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No fee nor funding increase is necessary to implement the administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The administrative regulation neither establishes nor increases any fee.

(9) Tiering: Is tiering applied? Tiering is not applied as this is a repealer administrative regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be affected by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by this administrative regulation. Not applicable, this administrative regulation is being repealed. KRS 194A.030(2), 194A.050(1), 205.520(3) and 42 U.S.C. 1396a authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation will generate no revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will generate no revenue for state or local government.

(d) How much will it cost to administer this program for the first year? This administrative regulation imposes no administrative cost on the Department for Medicaid Services.

(d) How much will it cost to administer this program for subsequent years? This administrative regulation imposes no administrative cost on the Department for Medicaid Services.
STATEMENT OF EMERGENCY

907 KAR 17:005E

This emergency administrative regulation is being promulgated concurrently with five (5) other administrative regulations which will establish the Kentucky Medicaid Program managed care organization requirements and policies. Currently, this administrative regulation establishes Kentucky Medicaid program managed care organization requirements and policies for every region except region three (3). Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or nearby Jefferson County. The requirements and policies are established in 907 KAR 1:705. One (1) managed care organization has been responsible for managed care in region three (3) since the mid-1990s; however, managed care in that region did not encompass behavioral health services and having one (1) entity does not satisfy the Centers for Medicare and Medicaid Services (CMS) requirement of providing individuals choice of managed care organizations. Consequently, DMS has contracted with four (4) entities — including the entity that has been performing managed care organization functions since the mid-1990s — to be responsible for managed care in region three (3) and the scope of managed care in region three (3) will now include behavioral health services. As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 1:705) and establishing uniform managed care organization requirements and policies for all Medicaid managed care organizations in Kentucky. The six (6) administrative regulations which will accomplish this include this administrative regulation; 907 KAR 17:010 (managed care organization requirements and policies related to enrollees); 907 KAR 17:015 (managed care organization requirements and policies related to providers); 907 KAR 17:020 (managed care organization service and service coverage requirements and policies); 907 KAR 17:025 (managed care organization utilization management, quality requirements and policies); and 907 KAR 17:030 (managed care organization operational and related requirements and policies.) DMS is establishing managed care organization requirements across multiple administrative regulations in response to urging from the Administrative Regulation Review Subcommittee (ARRS) and ARRS staff when this administrative regulation was reviewed by the committee earlier this year. Providing a choice of managed care organizations to individuals is necessary to comply with a federal mandate and expanding the scope of managed care in region three (3) to include behavioral health services is also necessary to establish the same managed care benefit package for all Medicaid recipients enrolled in managed care in Kentucky. This action must be implemented on an emergency basis to comply with a federal mandate. Effectiveness of services. (12) "Care coordination" means the integration of all pre-existing management; or (c) The denial, suspension, or termination of a previously authorized service; (d) The failure to provide services in a timely manner; or (e) The failure of a managed care organization to act within the timeframes provided in 42 C.F.R. 438.408(b).

7. "Behavioral health service" means a clinical, rehabilitative, or support service in an inpatient or outpatient setting to treat a mental illness, emotional disability, or substance abuse disorder.

8. "Blind" is defined by 42 U.S.C. 1382c(a)(2).

9. "Capitation payment" means the total per enrollee, per month payment amount the department pays an MCO.

10. "Capitation rate" means the negotiated amount to be paid on a monthly basis by the department to an MCO:

(1) Per enrollee; and
(2) Based on the enrollee's aid category, age, and gender.

11. "Case management" means a collaborative process that:

(a) Assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an enrollee's health and human service needs; and
(b) Is characterized by advocacy, communication, and resource management;

12. "Child" means a person who:

(a) Is under the age of eighteen (18) years;
(b) Is a full-time student in a secondary school or the equivalent level of vocational or technical training; and
(c) Is expected to complete the program before the age of nine-

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NOTE: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/–):

Expenditures (+/–):

Other Explanation:

RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R.
teen (19) years;
3. Is not self supporting;
4. Is not a participant in any of the United States Armed Forces; and
5. If previously emancipated by marriage, has returned to the home of his or her parents or to the home of another relative;
(b) Has not attained the age of nineteen (19) years in accordance with 42 U.S.C. 1396a(l)(1)(D); or
(c) Is under the age of nineteen (19) years if the person is a KCHIP recipient.

15[144] "Chronic Illness and Disability Payment System" means a diagnostic classification system that Medicaid programs use to make health-based, capped payments for TANF and Medicaid beneficiaries with a disability.

16[145] "Commission for Children with Special Health Care Needs" or "CCSHCN" means the Title V agency which provides specially medical services for children with specific diagnoses and health care needs that make them eligible to participate in programs sponsored by the CCSHCN, including the provision of medical care.

17[146] "Community mental health center" means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

18[147] "Complex or chronic condition" means a physical, behavioral, or developmental condition which:
(a) May have no known cure; (b) Is progressive; or
(c) Can be debilitating or fatal if left untreated or under-treated.

19[148] "Consumer Assessment of Healthcare Providers and Systems" or "CAHPS" means a program that develops standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care.

20[149] "Confidentiality commitment" means an involuntary commitment by an order of a court to a psychiatric facility for treatment pursuant to KRS Chapter 202A.

21[150] "DAIL" means the Department for Aging and Independent Living.

22[151] "DCBS" means the Department for Community Based Services.

23[152] "Department" means the Department for Medicaid Services or its designee.

24[153] "Disabled" is defined by 42 U.S.C. 1382c(a)(3).

25[154] "DSM-IV" is a manual published by the American Psychiatric Association that covers all mental health disorders for both children and adults.

26[155] "Dual eligible" means an individual eligible for Medicare and Medicaid benefits.

27[156] "Early and periodic screening, diagnosis and treatment" or "EPSDT" is defined by 42 C.F.R. 440.40(b).


29[158] "Encounter" means a health care visit of any type by an enrollee to a provider of care, drugs, items, or services.

30[159] "Enrollee" means a recipient who is enrolled with a managed care organization for the purpose of receiving Medicaid or KCHIP covered services.

31[160] "External quality review organization" or "EQRO":
(a) Is defined by 42 C.F.R. 438.320; and
(b) Includes any affiliate or designee of the EQRO.

32[161] "Family planning service" means a counseling service, medical service, or a pharmaceutical supply or device to prevent or delay pregnancy.

33[162] "Federa1ly qualified health center" or "FQHC" is defined by 42 C.F.R. 405.2401(b).

34[163] "Fee-for-service" means a reimbursement model in which a health insurer reimburses a provider for each service provided to a recipient.

35[164] "Foster care" is defined by KRS 620.020(5).

36[165] "Fraud" means any act that constitutes fraud under applicable federal law or KRS 205.8451 to KRS 205.8483.

37[166] "Grievance" is defined by 42 C.F.R. 438.400.

38[167] "Grievance system" means a system that includes a grievance process, an appeal process, and access to the Commonwealth of Kentucky’s fair hearing system.

39[168] "Health maintenance organization" is defined by KRS 304.38-030(5).

40[169] "Health risk assessment" or "HRA" means a health questionnaire used to provide individuals with an evaluation of their health risks and quality of life.

41[170] "Healthcare Effectiveness Data and Information Set" or "HEDIS" means a tool used to measure performance regarding important dimensions of health care or services.

42[171] "Homeless individual" means an individual who:
(a) Lacks a fixed, regular, or nighttime residence;
(b) Is at risk of becoming homeless in a rural or urban area because the residence is not safe, decent, sanitary, or secure;
(c) Has a primary nighttime residence at a:
1. Publicly or privately operated shelter designed to provide temporary living accommodations; or
2. Public or private place not designed as regular sleeping accommodations; or
(d) Lacks access to normal accommodations due to violence or the threat of violence from a cohabitant.

43[172] "Individual with a special health care need" or "I SHCN" means an individual who:
(a) Has, or is at a high risk of having, a chronic, physical, developmental, behavioral, neurological, or emotional condition; and
(b) May require a broad range of primary, specialized, medical, behavioral health, or related services.

44[173] "Initial implementation" means the process of transitioning a current Medicaid or KCHIP recipient from fee-for-service into managed care.

45[174] "KCHIP" means the Kentucky Children’s Health Insurance Program administered in accordance with 42 U.S.C. 1397aa to j.

46[175] "Kentucky Health Information Exchange" or "KHIE" means the name given to the system that will support the statewide exchange of health information among healthcare providers and organizations according to nationally-recognized standards.

47[176] "Managed care organization" or "MCO" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

48[177] "Marketing" means any activity conducted by or on behalf of an MCO in which information regarding the services offered by the MCO is disseminated in order to educate enrollees or potential enrollees about the MCO’s services.

49[178] "Maternity care" means prenatal, delivery, and postpartum care and includes care related to complications from delivery.

50[179] "Medicaid works individual" means an individual who:
(a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be receiving SSI benefits;
(b) Is at least sixteen (16), but less than sixty-five (65), years of age;
(c) Is engaged in active employment verifiable with:
1. Paycheck stubs;
2. Tax returns;
3. 1099 forms; or
4. Proof of quarterly estimated tax;
(d) Meets the income standards established in 907 KAR 1:640; and
(e) Meets the resource standards established in 907 KAR 1:645.

51[180] "Medical record" means a single, complete record that documents all of the treatment plans developed for, and medical services received by, an individual.

52[181] "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

53[182] "Medicare qualified individual group 1 (QI-1)" means an eligibility category, in which pursuant to 42 U.S.C. 1396a(a)(10)(E)(iv), an individual who would be a Qualified Medicaid beneficiary but for the fact that the individual’s income:
(a) Exceeds the income level established in accordance with 42 U.S.C. 1396d(p)(2); and
(b) Is at least 120 percent, but less than 135 percent, of the federal poverty level for a family of the size involved and who are
not otherwise eligible for Medicaid under the state plan. A "National Practitioner Data Bank" means an electronic repository that collects:
(a) Information on adverse licensure activities, certain actions restricting clinical privileges, and professional society membership actions taken against physicians, dentists, and other practitioners; and
(b) Data on payments made on behalf of physicians in connection with liability settlements and judgments.

"Nonqualified alien" means a resident of the United States who does not meet the qualified alien requirements established in 907 KAR 1:011, Section 5(12).

"Nursing facility" means:
(a) A facility:
1. To which the state survey agency has granted a nursing facility license;
2. For which the state survey agency has recommended to the department certification as a Medicaid provider; and
(b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt and 1396i, if the swing bed is certified to the department as meeting requirements for the provision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), and (d) and 42 C.F.R. 447.280 and 482.66.

"Obstetrical decision" means the court decision of Olmstead v. L.C. and E.W., U.S. Supreme Court, June 26, 1999 in which the U.S. Supreme Court ruled, "For the reasons stated, we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

"Open enrollment" means an annual period during which an enrollee can choose a different MCO.

"Out-of-network provider" means a person or entity that has not entered into a participating provider agreement with an MCO or any of the MCO's subcontractors.

"Physician" is defined by KRS 311.550(12).

"Post-stabilization services" means covered services related to an emergency medical condition that are provided to an enrollee:
(a) After an enrollee is stabilized in order to maintain the stabilized condition; or
(b) Under the circumstances described in 42 C.F.R. 438.114(e) to improve or resolve the enrollee's condition.

"Primary care center" means an entity that meets the primary care center requirements established in 902 KAR 20:058.

"Primary care provider" or "PCP" means a licensed or certified health care practitioner who meets the description as established in 907 KAR 17:010, Section 7(6) of this administrative regulation.

"Prior authorization" means the advance approval by an MCO of a service or item provided to an enrollee.

"Provider" means any person or entity under contract with an MCO or its contractual agent that provides covered services to enrollees.

"Provider network" means the group of physicians, hospitals, and other medical care professionals that a managed care organization has contracted with to deliver medical services to its enrollees.

"QAPI" means the Quality Assessment and Performance Improvement Program established in accordance with 907 KAR 17:025, Section 5 of this administrative regulation.

"Qualified alien" means an alien who, at the time of applying for or receiving Medicaid benefits, meets the requirements established in 907 KAR 1:011, Section 5(12).""Qualified disabled and working individual" is defined by 42 U.S.C. 1396d(s).

"Qualified Medicare beneficiary" or "QMB" is defined by 42 U.S.C. 1396d(p)(1).

"Quality improvement" or "QI" means the process of assuring that covered services provided to enrollees are appropriate, timely, accessible, available, and medically necessary and the level of performance of key processes and outcomes of the health-care delivery system is improved through the MCO's policies and procedures.

"Recipient" is defined in KRS 205.8451(9).

"Region eight (8)" means the region containing Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe Counties.

"Region five (5)" means the region containing Anderson, Boyd, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harlan, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, and Woodford Counties.

"Region four (4)" means the region containing Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, and Wayne Counties.

"Region one (1)" means the region containing Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, and McCracken Counties.

"Region seven (7)" means the region containing Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, and Rowan Counties.

"Region six (6)" means the region containing Boone, Campbell, Gallatin, Grant, Kenton, and Pendleton Counties.

"Region three (3)" means the region containing Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington Counties.

"Region two (2)" means the region containing Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, and Webster Counties.

"Risk adjustment" means a corrective tool to reduce both the negative financial consequences for a managed care organization that enrols high-risk users and the positive financial consequences for a managed care organization that enrols low-risk users.

"Rural area" means an area not in an urban area.

"Rural health clinic" is defined by 42 C.F.R. 482.301(b).

"Specialist" means a provider who provides specialty care.

"Specialty care" means care or a service that is provided by a provider who is:
(a) A primary care provider; or
(b) Acting in the capacity of a primary care provider while providing the service.

"Specified low-income Medicare beneficiary" means an individual who meets the requirements established in 42 U.S.C. 1396a(a)(10)(E)(iii).

"State fair hearing" means an administrative hearing provided by the Cabinet for Health and Family Services pursuant to KRS Chapter 13B and 907 KAR 1:563.

"State plan" is defined by 42 C.F.R. 400.203.

"State survey agency" means the Cabinet for Health and Family Services, Office of Inspector General, Division of Health Care Facilities and Services.

"State-funded adoption assistance" is defined by KRS 199.555(2).

"Subcontract" means an agreement entered into, directly or indirectly, by an MCO to arrange for the provision of covered services, or any administrative, support or other health service, but does not include an agreement with a provider.

"Supplemental security income benefits" or "SSI benefits" is defined by 20 C.F.R. 416.2101.

"Teaching hospital" means a hospital which has a teaching program approved as specified in 42 U.S.C. 1395x(b)(6).

"Temporary Need for Continuation of Coverage" means a block grant program which is designed to:
(a) Assist needy families so that children can be cared for in their own homes;
(b) Reduce the dependency of needy parents by promoting job preparation, work, and marriage;
(c) Prevent out-of-wedlock pregnancies; and
(d) Encourage the formation and maintenance of two-parent families.

"Third party liability resource" means a resource available to an enrollee for the payment of expenses:
(a) Associated with the provision of covered services; and
(b) That does not include amounts exempt under Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396v.

"Transport time" means travel time:
(a) Under normal driving conditions; and
(b) With no extenuating circumstances.

"Urban area" is defined by 42 C.F.R. 412.62(f)(1)(i).

"Urgent care" means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

"Ward" is defined in KRS 387.510(15).

"Women, Infants and Children program" means a federally-funded health and nutrition program for women, infants, and children.

Enrollment of Medicaid or KCHIP Recipients into Managed Care. (1) Except as provided in subsection (2) of this section, enrollment into a managed care organization shall be mandatory for a Medicaid or KCHIP recipient.

(2) The provisions in this administrative regulation shall be applicable to:
(a) Medicaid recipient; or
(b) KCHIP recipient.

(3) The following recipients shall not be required to enroll, and shall not enroll into a managed care organization:
(a) A recipient who resides in:
1. A nursing facility for more than thirty (30) days; or
2. An intermediate care facility for individuals with mental retardation or a developmental disability; or
(b) A recipient who is:
1. Determined to be eligible for Medicaid benefits due to a nursing facility admission;
2. Enrolled in another managed care program in accordance with 907 KAR 1:705;
3. Receiving;
   a. Services through the breast and cervical cancer program pursuant to 907 KAR 1:905;
   b. Medicare benefits in accordance with the spend-down policy established in 907 KAR 1:640;
   c. Services through a 1915(c) home and community-based services waiver program;
   d. Hospice services in a nursing facility or intermediate care facility for individuals with mental retardation or a developmental disability; or
   e. Medicaid benefits as a Medicaid Works individual;
4. A Qualified Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
5. A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
6. A Medicare qualified individual group 1 (QI-1) individual;
7. A qualified disabled and working individual;
8. A qualified alien eligible for Medicaid benefits for a limited period of time; or
9. A nonqualified alien eligible for Medicaid benefits for a limited period of time.

(4)(a) Except for a child in foster care, a recipient who is eligible for enrollment into managed care shall be enrolled with an MCO that provides services to an enrollee whose primary residence is within the MCO’s service area.

(b) A child in foster care shall be enrolled with an MCO in the county where the child’s DCBS case is located.

(5)(a) During the department’s initial implementation of managed care in accordance with this administrative regulation, the department shall assign a recipient to an MCO based upon an algorithm that considers:
1. Continuity of care;
2. Enrollee preference of MCO or of an MCO provider; and
3. Cost.

(b) An assignment shall focus on a need of a child or an individual with a special health care need.

(6)(a) A newly eligible recipient or a recipient who has had a break in eligibility of greater than two (2) months shall have an opportunity to choose an MCO during the eligibility application process.

(b) If a recipient does not choose an MCO during the eligibility application process, the department shall assign the recipient to an MCO.

(7) Each member of a household shall be assigned to the same MCO.

(8) The effective date of enrollment for a recipient described in subsection (6)(b) of this section shall be:
(a) The date of Medicaid eligibility; and
(b) No earlier than November 1, 2011.

(9) A recipient shall be given a choice of MCOs.

(10) A recipient enrolled with an MCO who loses Medicaid eligibility for less than two (2) months shall be automatically reenrolled with the same MCO upon redetermination of Medicaid eligibility unless the recipient moves to a county in region three (3) as established in Section 28 of this administrative regulation.

(11) A newborn who has been deemed eligible for Medicaid shall be automatically enrolled with the newborn’s mother’s MCO as an individual enrollee for up to sixty (60) days.

(12) An enrollee may change an MCO for any reason, regardless of whether the MCO was selected by the enrollee or assigned by the department:
1. Within ninety (90) days of the effective date of enrollment;
2. Annually during an open enrollment period that shall be at the time of an enrollee’s recertification for Medicaid eligibility; or
3. Annually during the month of birth for an enrollee who receives SSI benefits;
4. Upon automatic enrollment under subsection (10) of this section, if a temporary loss of Medicaid eligibility caused the recipient to miss the annual opportunity in subparagraph 2. of this paragraph;

(b) An MCO shall accept an enrollee who changes MCOs under this section.

(13) Only the department shall have the authority to enroll a Medicaid recipient with an MCO in accordance with this section.

(14) Upon enrollment with an MCO, an enrollee shall receive two (2) identification cards:
(a) A card shall be issued from the department that shall verify Medicaid eligibility.
(b) A card shall be issued by the MCO that shall verify enrollment with the MCO.

(15)(a) Within five (5) business days after receipt of notification of a new enrollee, an MCO shall send, by a method that shall not take more than three (3) days to reach the enrollee, a confirmation letter to an enrollee.

(b) The confirmation letter shall include at least the following information:
1. The effective date of enrollment;
2. The name, location and contact information of the PCP;
3. How to obtain a referral;
4. Care coordination;
5. The benefits of preventive health care;
6. The enrollee identification card;
7. A member handbook; and
8. A list of covered services.

(16) Enrollment with an MCO shall be without restriction.

(17) An MCO shall:
(a) Have continuous open enrollment for new enrollees; and
(b) Accept enrollees regardless of overall enrollment.

(18) An MCO shall:
(a) Except as provided in paragraph (b) of this subsection, a recipient eligible to enroll with an MCO shall be enrolled beginning with the first day of the month that the enrollee applied for Medicaid.

(b) A newborn shall be enrolled beginning with the newborn’s date of birth.

2. An unemployed parent shall be enrolled beginning with the date the unemployed parent met the definition of unemployment in accordance with 45 C.F.R. 233.100.

3. If an enrollee is retroactively determined eligible for Medicaid, the retro-active eligibility shall be for a period up to three (3)
Section 3. Disenrollment. (1) The policies established in 42 C.F.R. 438.56 shall apply to an MCO.
   (2) Only the department shall have the authority to disenroll a recipient from an MCO.
   (3) A disenrollment of a recipient from an MCO shall:
      (a) Become effective on the first day of the month following disenrollment; and
      (b) Occur:
         1. If the enrollee:
            a. No longer resides in an area served by the MCO;
            b. Is incarcerated or deceased;
            c. Is exempt from managed care enrollment in accordance with Section 2(3) of this administrative regulation; or
            d. No longer resides in an area served by the MCO.
         2. If the department fails to make a determination within the scheduled timeframe set forth in 42 C.F.R. 438.56(11), the MCO shall have thirty (30) calendar days from the date an oral or written request for a grievance is received by the MCO to have a hearing scheduled.
         (4) An MCO may recommend to the department that an enrollee be disenrolled if the enrollee:
            (a) Is found guilty of fraud in a court of law or administratively determined to have committed fraud related to the Medicaid Program;
            (b) Is abusive or threatening but not for inoperative or disruptive behavior resulting from his or her special needs (except if his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); pursuant to 42 C.F.R. 438.56(b)(2);
            (c) Becomes incarcerated or deceased;
            (d) No longer resides in an area served by the MCO.
   (5) An enrollee shall not be disenrolled by the department, nor shall the managed care organization recommend disenrollment of an enrollee, due to an adverse change in the enrollee's health.
   (6)(a) An approved disenrollment shall be effective no later than the first day of the second month following the month the enrollee or the MCO files a request in accordance with 42 C.F.R. 438.56(e)(1).
   (b) If the department fails to make a determination within the timeframe specified in paragraph (a) of this subsection, the disenrollment shall be considered approved in accordance with 42 C.F.R. 438.56(e)(2).
   (7) If an enrollee is disenrolled from an MCO, the:
      (a) Enrollee shall be enrolled with a new MCO if the enrollee is:
         1. Eligible for Medicaid; and
         2. Not excluded from managed care participation; and
      (b) MCO shall:
         1. Assist in the selection of a new primary care provider, if requested;
         2. Cooperate with the new primary care provider in transitioning the enrollee's care; and
         3. Make the enrollee's medical record available to the new primary care provider in accordance with state and federal law.
   (8) An MCO shall notify the department or Social Security Administration in an enrollee's county of residence within five (5) working days of receiving notice of the death of an enrollee.

Section 4. Enrollee Rights and Responsibilities. (1) An MCO shall have written policies and procedures:
   (a) To protect the rights of an enrollee that includes the:
      1. Protection against liability for payment in accordance with 42 U.S.C. 1396u-2(b)(6);
      2. Rights specified in 42 C.F.R. 438.100;
      3. Right to prepare an advance medical directive pursuant to KRS 311.621 through KRS 311.643;
      4. Right to choose and change a primary care provider;
      5. Right to file a grievance or appeal;
      6. Right to receive assistance in filing a grievance or appeal;
      7. Right to a state fair hearing;
      8. Right to a timely referral and access to medically indicated specialty care; and
      9. Right to access the enrollee's medical records in accordance with federal and state law; and
   (b) Regarding the responsibilities of enrollees that include the responsibility to:
      1. Become informed about:
         a. Enrollee rights specified in paragraph (a) of this subsection; and
         b. Service and treatment options;
      2. Abide by the MCO's and department's policies and procedures;
      3. Actively participate in personal health and care decisions;
      4. Report suspected fraud or abuse; and
      5. Keep appointments or call to cancel if unavailable to keep an appointment.
   (2) The information specified in subsection (1) of this section shall meet the information requirements established in 42 C.F.R. 438.10.
adverse action is treated as an appeal to establish the earliest possible filing date for the appeal.

(12) An oral appeal shall be followed by a written appeal that is signed by the enrollee within ten (10) calendar days.

(13) Within fifteen (15) working days of receipt of an appeal, an MCO shall provide the enrollee with written notice that the appeal has been received and the expected date of its resolution, unless an expedited resolution has been requested.

(14) An MCO shall extend the thirty (30) day timeframe for resolution of an appeal established in subsection (10) of this section by fourteen (14) calendar days if:
(a) The enrollee requests the extension; or
(b) The MCO demonstrates to the department that there is need for additional information; and
2. The extension is in the enrollee’s interest.

(15) For an extension requested by an MCO, the MCO shall give the enrollee written notice of the extension and the reason for the extension within two (2) working days of the decision to extend.

(16) For an extension, if the enrollee, the MCO shall provide written notice of its decision within thirty (30) calendar days to an enrollee or a provider, if the provider filed the appeal. The provider shall:
(a) Give a copy of the notice to the enrollee; or
(b) Inform the enrollee of the provisions of the notice.

(17) An MCO shall:
(a) Continue to provide benefits to an enrollee, if the enrollee requested a continuation of benefits, until one of the following occurs:
1. The enrollee withdraws the appeal;
2. Fourteen (14) days have passed since the date of the resolution letter, if the resolution of the appeal was against the enrollee and the enrollee has not requested a state fair hearing or taken any further action; or
3. A state fair hearing decision adverse to the enrollee has been issued.
(b) Have an expedited review process for appeals if the MCO determines that allowing the time for a standard resolution could seriously jeopardize an enrollee’s life or health or ability to attain, maintain, or regain maximum function;
(c) Resolve an expedited appeal within three (3) working days of receipt of the request; and
(d) Extend the timeframe for an expedited appeal established in paragraph (a) of this subsection by up to fourteen (14) calendar days if:
1. The enrollee requests the extension; or
2. The MCO demonstrates to the department that there is need for additional information; and
b. The extension is in the enrollee’s interest.

(18) For an expedited appeal requested by an MCO, the MCO shall give the enrollee written notice of the reason for the extension.

(19) If an MCO denies a request for an expedited resolution of an appeal, it shall:
(a) Transfer the appeal to the thirty (30) day timeframe for a standard resolution, in which the thirty (30) day period shall begin on the date the MCO received the original request for appeal;
(b) Give prompt oral notice of the denial; and
(c) Follow up with a written notice within two (2) calendar days of the denial.

(20) An MCO shall document in writing an oral request for an expedited resolution and shall maintain the documentation in the enrollee case file.

(21) The department shall provide an enrollee with a hearing process that shall adhere to 907 KAR 1:563, 42 C.F.R. 438 Subpart E and 42 C.F.R. 431 Subpart E.

(22) An enrollee shall be able to request a state fair hearing if dissatisfied with an adverse action that has been taken by a MCO:
(a) Within thirty (30) days of receiving notice of an adverse action; or
(b) Within thirty (30) days of the final decision of an MCO to an appeal filed by the enrollee.

(23) A document supporting an MCO’s adverse action shall be:
(a) Received by the department no later than five (5) days from the date the MCO receives a notice from the department that a request for a state fair hearing has been filed by an enrollee; and
(b) Made available to an enrollee upon request by either the enrollee or the enrollee’s legal counsel.

(24) An automatic ruling shall be made by the department in favor of an enrollee if an MCO fails to:
(a) Comply with the state fair hearing requirements established by the state and federal Medicaid law; or
(b) Appear in person and present evidence at the state fair hearing.

(25) An MCO shall:
(a) Provide information specified in 42 C.F.R. 438.10(g)(1) about the grievance system to a service provider and a subcontractor at the time they enter into a contract;
(b) Maintain a grievance or an appeal file in a secure and designated area;
(c) Make a grievance or an appeal file accessible to the department or its designee upon request;
(d) Retain a grievance or an appeal file for ten (10) years following a final decision by the MCO, the department, an administrator, law judge, judicial appeal, or closure of a file, whichever occurs later;
(e) Have procedures for assuring that a grievance or an appeal file contains:
1. Information to identify the grievance or appeal;
2. The date a grievance or appeal was received;
3. The nature of the grievance or appeal;
4. A notice to the enrollee of receipt of the grievance or appeal;
5. Correspondence between the MCO and the enrollee;
6. The date the grievance or appeal is resolved;
7. The decision made by the MCO of the grievance or appeal;
8. The notice of a final decision to the enrollee; and
9. Information pertaining to the grievance or appeal, and
(f) Make available to an enrollee documentation regarding a grievance or an appeal.

(26) An MCO shall designate an individual to:
(a) Execute the policies and procedures for resolution of a grievance or appeal;
(b) Review patterns or trends in grievances or appeals; and
(c) Initiate a corrective action, if needed.

Section 6. Member Services. (1) An MCO shall have a member services function that includes a member call center and a behavioral health call center that shall:
(a) Be staffed Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Time; and
(b) Meet the call center standards, which shall:
1. Be approved by the American Accreditation Health Care Commission or Utilization Review Accreditation Committee (URAC); and
2. Include provisions addressing the call center abandonment rate, blockage rate and average speed of answer.

(22) An MCO shall provide access to medical advice to an enrollee through a toll-free call-in system available twenty-four (24) hours a day, seven (7) days a week.

(23) The call-in system shall be staffed by medical professionals to include:
1. Physicians;
2. Physician assistants;
3. Licensed practical nurses; or
4. Registered nurses.

(26) An MCO shall:
(a) Provide foreign language interpreter services, free of charge, for an enrollee;
(b) Respond to the special communication needs of the disabled, blind, deaf, or aged;
(c) Facilitate direct access to a specialty physician for an enrollee
1. With a chronic or complex health condition;
2. Who is aged, blind, deaf, or disabled; or
3. Identified as having a special healthcare need and requiring a course of treatment or regular healthcare monitoring;
(d) Arrange for and assist with scheduling an EPSDT service in conformance with federal law governing EPSDT.

(27) An MCO shall:
(a) Provide an enrollee with information or refer the enrollee to
Section 7. Enrollee Selection of Primary Care Provider. (1) Except for an enrollee described in subsection (2) of this section, an MCO shall have a process for enrollee selection and assignment of a primary care provider.

(2) The following shall not be required to have a primary care provider:

(a) A dual eligible.
(b) A child in foster care.
(c) A child under the age of eighteen (18) years who is disabled.
(d) A pregnant woman who is presumptively eligible pursuant to 5 KAR 1:810.

(3)(a) For an enrollee who is not receiving supplemental security income benefits:

1. An MCO shall notify the enrollee within ten (10) days of notification of enrollment by the department of the procedure for choosing a primary care provider; and

2. If the enrollee does not choose a primary care provider, an MCO shall assign to the enrollee a primary care provider who:
   (a) Has historically provided services to the enrollee; and
   (b) Meets the requirements of subsection (b) of this section.

(b) If no primary care provider meets the requirements of paragraph (a) of this subsection, an MCO shall assign the enrollee to a primary care provider who is within:

1. Thirty (30) miles or thirty (30) minutes from the enrollee's residence or place of employment if the enrollee is in an urban area;
2. Forty-five (45) miles or forty-five (45) minutes from the enrollee's residence or place of employment if the enrollee is in a rural area;

(c) For an enrollee who is receiving supplemental security income benefits and is not a dual eligible, an MCO shall notify the enrollee of the procedure for choosing a primary care provider.

(d) If an enrollee has not chosen a primary care provider within thirty (30) days, an MCO shall send a second notice to the enrollee.

(c) If an enrollee has not chosen a primary care provider within thirty (30) days of the second notice, the MCO shall send a third notice to the enrollee.

(d) If an enrollee has not chosen a primary care provider after the third notice, the MCO shall assign a primary care provider.

(4)(a) Except for an enrollee who was previously enrolled with the MCO, an MCO shall not automatically assign a primary care provider within ninety (90) days of the enrollee's initial enrollment.

(5)(a) An enrollee shall be allowed to select from at least two (2) primary care providers within an MCO's provider network.

(b) At least one (1) of the two (2) primary care providers referenced in paragraph (a) of this subsection shall be a physician.

(6) A primary care provider shall:

(a) Be a licensed or certified health care practitioner who functions within the provider's scope of licensure or certification, including:

1. A physician.
2. An advanced practice registered nurse.
3. A physician assistant.
4. A clinic, including a primary care center, federally qualified health center, or rural health clinic.
(b) Have admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges.
(c) Agree to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to enrollees; and

(d) For an enrollee who has a gynecological or obstetrical health care need, a disability, or chronic illness, be a specialist who agrees to provide or arrange for primary and preventive care directly or through linkage with a primary care provider.

(7) Upon enrollment in an MCO, an enrollee shall have the right to change primary care providers:

(a) Within the first ninety (90) days of assignment;
(b) Once a year regardless of reason;
(c) At any time for a reason approved by the MCO; or
(d) During a time period provided for other medically necessary services.

(8) A PCP shall not be able to request the reassignment of an enrollee to a different PCP for the following reasons:

(a) A change in the enrollee's health status or treatment needs;
(b) An enrollee's utilization of health services;
(c) An enrollee's diminished mental capacity;
(d) A disruptive, behavior, or attitude of the enrollee.

(9) A PCP shall not be able to request a primary care provider change:

(a) Upon the enrollee's request.
(b) For an enrollee who has a gynecological or obstetrical health care need, a disability, or chronic illness.

(10) An MCO shall have the authority to approve or deny a primary care provider change.

(11) An enrollee shall be able to obtain the following services without changing his or her MCO's primary care network:

(a) A family planning service in accordance with 42 C.F.R. 431.51;
(b) An emergency service in accordance with 42 C.F.R. 438.114;
(c) A poststabilization service in accordance with 42 C.F.R. 431.114 and 42 C.F.R. 422.113(c); or
(d) An out-of-network service that an MCO is unable to provide within its network to meet the medical needs of the enrollee in accordance with 42 C.F.R. 438.206(b)(4).

(12) An MCO shall:

(a) Notify an enrollee within:
   1. Thirty (30) days of the effective date of a voluntary termination of the enrollee's primary care provider; or
   2. Fifteen (15) days of an involuntary termination of the enrollee's primary care provider; and

(b) Assist the enrollee in selecting a new primary care provider.

Section 8. Primary Care Provider Responsibilities. (1) A PCP shall:

(a) Maintain:
   1. Continuity of an enrollee's health care;
   2. A current medical record for an enrollee in accordance with Section 24 of this administrative regulation; and
   3. Formalized relationships with other PCPs to refer enrollees for after-hours care, during certain days, for certain services, or other reasons to extend their practice;

(b) Refer an enrollee for specialty care or other medically necessary services, both in and out of network, if the services are not available within the MCO's network;

(c) Discuss advance medical directives with an enrollee;

(d) Provide primary and preventive care, including EPSDT services;

(e) Refer an enrollee for a behavioral health service if clinically necessary.

A support service:

(f) Facilitate direct access to a covered service in accordance with Section 24(a) of this administrative regulation.

(g) Facilitate access to:

1. Behavioral health services;
2. Pharmaceutical service; or
3. Service provided by a public health department, community mental health center, rural health clinic, federally qualified health center, the Commission for Children with Special Health Care Needs, or a charitable care provider;

(h) Assist an enrollee in:

1. Scheduling an appointment with a provider;
2. Obtaining transportation for an emergency or non-emergency service;
3. Completing a health risk assessment; or
4. Accessing an MCO health education program.

(i) Process, record, and track an enrollee's grievance and appeal;

(j) Refer an enrollee to case management or disease management.

Section 8. Primary Care Provider Responsibilities. (1) A PCP shall:

(a) Maintain:

1. Continuity of an enrollee's health care;
2. A current medical record for an enrollee in accordance with Section 24 of this administrative regulation; and
3. Formalized relationships with other PCPs to refer enrollees for after-hours care, during certain days, for certain services, or other reasons to extend their practice;

(b) Refer an enrollee for specialty care or other medically necessary services, both in and out of network, if the services are not available within the MCO's network;

(c) Discuss advance medical directives with an enrollee;

(d) Provide primary and preventive care, including EPSDT services;

(e) Refer an enrollee for a behavioral health service if clinically necessary.

A support service:

(f) Facilitate direct access to a covered service in accordance with Section 24(a) of this administrative regulation.

(g) Facilitate access to:

1. Behavioral health services;
2. Pharmaceutical service; or
3. Service provided by a public health department, community mental health center, rural health clinic, federally qualified health center, the Commission for Children with Special Health Care Needs, or a charitable care provider;

(h) Assist an enrollee in:

1. Scheduling an appointment with a provider;
2. Obtaining transportation for an emergency or non-emergency service;
3. Completing a health risk assessment; or
4. Accessing an MCO health education program.

(i) Process, record, and track an enrollee's grievance and appeal;

(j) Refer an enrollee to case management or disease management.

Section 8. Primary Care Provider Responsibilities. (1) A PCP shall:

(a) Maintain:

1. Continuity of an enrollee's health care;
2. A current medical record for an enrollee in accordance with Section 24 of this administrative regulation; and
3. Formalized relationships with other PCPs to refer enrollees for after-hours care, during certain days, for certain services, or other reasons to extend their practice;

(b) Refer an enrollee for specialty care or other medically necessary services, both in and out of network, if the services are not available within the MCO's network;

(c) Discuss advance medical directives with an enrollee;

(d) Provide primary and preventive care, including EPSDT services;

(e) Refer an enrollee for a behavioral health service if clinically necessary.

A support service:

(f) Facilitate direct access to a covered service in accordance with Section 24(a) of this administrative regulation.

(g) Facilitate access to:

1. Behavioral health services;
2. Pharmaceutical service; or
3. Service provided by a public health department, community mental health center, rural health clinic, federally qualified health center, the Commission for Children with Special Health Care Needs, or a charitable care provider;

(h) Assist an enrollee in:

1. Scheduling an appointment with a provider;
2. Obtaining transportation for an emergency or non-emergency service;
3. Completing a health risk assessment; or
4. Accessing an MCO health education program.

(i) Process, record, and track an enrollee's grievance and appeal;

(j) Refer an enrollee to case management or disease management.
indicated; and
(f) Have an after-hours phone arrangement that ensures that a PCP or a designated medical practitioner returns the call within thirty (30) minutes.
(2) An MCO shall monitor a PCP to ensure compliance with the requirements established in this section.

Section 9. Member Handbook. (1) An MCO shall:
(a) Send a member handbook to an enrollee, by a method that shall not take more than three (3) days to reach the enrollee, within five (5) business days of enrollment;
(b) Review the member handbook at least annually;
(c) Communicate a change to the member handbook to an enrollee in writing; and
(d) Add a revision date to the member handbook after revising the member handbook.
(2) A member handbook shall:
(a) Be available:
1. In hardcopy in English, Spanish, and any other language spoken by at least five (5) percent of the potential enrollee or enrollee population; and
2. On the MCO's Web site;
(b) Be written at no higher than a sixth-grade reading comprehension level; and
(c) Include at a minimum the following information:
1. An MCO's network of primary care providers, including the names, telephone numbers, and service site addresses of available primary care providers, and, if desired by the MCO, the names and contact information for other providers included in the MCO's network;
2. The procedures for:
   a. Selecting a PCP and scheduling an initial health appointment;
   b. Obtaining:
      (i) Emergency or non-emergency care after hours;
      (ii) Transportation for emergency or non-emergency care;
      (iii) EPSDT services;
      (iv) A covered service from an out-of-network provider; or
      (v) A long-term care service;
   c. Notifying DCBS of a change in family size or address, a birth, or a death of an enrollee;
   d. (i) Selecting or requesting to change a PCP;
      (ii) A reason for a request for a change may be denied by the MCO;
      (iii) A reason a provider may request to transfer an enrollee to a different PCP; and
      (iv) Filing a grievance or appeal, including the title, address, and telephone number of the person responsible for processing and resolving a grievance or appeal;
3. The name of the MCO, address, and telephone number from which it conducts its business;
4. The MCO's:
   a. Business hours; and
   b. Member service and toll-free medical call-in telephone numbers;
5. Covered services, an explanation of any service limitation or exclusion from coverage, and a notice stating that the MCO shall be liable only for those services authorized by the MCO, except for the services excluded in Section 7(11) of this administrative regulation;
6. Member rights and responsibilities;
7. For a life-threatening situation, instructions to use the emergency medical services available or to activate emergency medical services by dialing 911;
8. Information on:
   a. The availability of maternity and family planning services, and for the prevention and treatment of sexually transmitted diseases;
   b. Accessing the services referenced in clause a. of this paragraph;
   c. Accessing care before a primary care provider is assigned or chosen;
   d. The Cabinet for Health and Family Services' independent ombudsman program; and
   e. The availability of, and procedures for, obtaining:
      (i) A behavioral health or substance abuse service;
      (ii) A health education service; and
      (iii) Care coordination, case management, and disease management services;
9. Direct access services that may be accessed without a referral; and
10. An enrollee's right to obtain a second opinion and information on obtaining a second opinion; and
(c) Meet the information requirements established in Section 12 of this administrative regulation.
(3) Changes to the member handbook shall be approved by the department prior to the publication of the handbook.

Section 10. Member Education and Outreach. (1) An MCO shall:
(a) Have an enrollee and community education and outreach program throughout the MCO's service area;
(b) Submit an annual outreach plan to the department for approval;
(c) Assess the homeless population within its service area by implementing and maintaining an outreach plan for homeless individuals, including victims of domestic violence; and
(d) Not differentiate between a service provided to an enrollee who is homeless and an enrollee who is not homeless.
(2) An MCO's outreach plan shall include:
(a) Utilizing existing community resources including shelters and clinics; and
(b) Face-to-face encounters.

Section 11. Enrollee Non-Liability for Payment. (1) Except as specified in Section 58 of this administrative regulation, an enrollee shall not be required to pay for a medically necessary, covered service provided by the enrollee's MCO.
(2) An MCO shall not impose cost sharing on an enrollee greater than the limits established by the department in 907 KAR 1:604.
(3) If an enrollee agrees, in advance and in writing, to pay for a non-Medicare covered service, the provider of the service shall be authorized to bill the enrollee for the service.

Section 12. Provision of Information Requirements. (1) An MCO shall:
(a) Comply with the requirements established in 42 U.S.C. 1396u-2(a)(5) and 42 C.F.R. 438.10; and
(b) Provide translation services to an enrollee on site or via telephone.
(2) Written material provided by an MCO to an enrollee or potential enrollee shall:
(a) Be written at a sixth-grade reading comprehension level;
(b) Be published in at least a twelve (12) point font;
(c) Comply with the requirements established in 42 U.S.C. Chapter 126, the Americans with Disabilities Act;
(d) Be updated as necessary to maintain accuracy;
(e) Be available in Braille or in an audio format for an individual who is partially blind or blind; and
(f) Be provided and printed in each language spoken by five (5) percent or more of the enrollees in each county.
(3) All written material intended for an enrollee, unless unique to an individual enrollee or exempted by the department, shall be submitted to the department for review and approval prior to publication or distribution to the enrollee.

Section 13. Provider Services. (1) An MCO shall have a provider services function responsible for:
(a) Enrolling, credentialing, recredentialing, and evaluating a provider;
(b) Assisting a provider with an inquiry regarding enrollee status, prior authorization, referral, claim submission, or payment;
(c) Informing a provider of the provider's rights and responsibilities;
(d) Handling, recording, and tracking a provider grievance and appeal;
(e) Developing, distributing, and maintaining a provider ma-
(f) Provider orientation and training, including:
1. Medicaid covered services;
2. EPSDT coverage;
3. Medicaid policies and procedures;
4. MCO policies and procedures; and
5. Fraud, waste, and abuse;
(g) Assisting in coordinating care for a child or adult with a complex or chronic condition;
(h) Assisting a provider with enrolling in the Vaccines for Children Program in accordance with 907 KAR 1:680; and
(i) Providing technical support to a provider regarding the provision of a service.
(2) An MCO's provider services staff shall:
(a) Be available at a minimum Monday through Friday from 8:00 a.m. to 6:00 p.m. Eastern Time; and
(b) Operate a provider call center.

Section 14. Provider Network. (1) An MCO shall:
(a) Enroll providers of sufficient types, numbers, and specialties in its network to satisfy the:
1. Access and capacity requirements established in Section 15 of this administrative regulation; and
2. Quality requirements established in Section 48 of this administrative regulation;
(b) Attempt to enroll the following providers in its network:
1. A teaching hospital;
2. A rural health clinic;
3. The Kentucky Commission for Children with Special Health Care Needs;
4. A local health department; and
5. A community mental health center;
(c) Demonstrate in writing the extent to which it has enrolled providers in its network who have traditionally provided services to Medicaid recipients;
(d) Have at least one (1) FQHC in a region where the MCO operates in accordance with Section 28 of this administrative regulation, if there is an FQHC that is licensed to provide services in the region; and
(e) Exclude, terminate, or suspend from its network a provider or subcontractor who engages in an activity that results in suspension, termination, or exclusion from the Medicare or a Medicaid program.
(2) The length of an exclusion, termination, or suspension referenced in subsection (1)(c) of this section shall equal the length of the exclusion, termination, or suspension imposed by the Medicare or a Medicaid program.
(i) An MCO unable to enroll a provider specified in subsection (1)(b) or (c) of this section, the MCO shall submit to the department for approval, documentation which supports the MCO's conclusion that adequate services and service sites as required in Section 15 of this administrative regulation shall be provided without enrolling the specified provider.
(ii) If an MCO determines that its provider network is inadequate to comply with the access standards established in Section 15 of this administrative regulation, the MCO shall:
(a) Notify the department; and
(b) Submit a corrective action plan to the department.
(3) A corrective action plan referenced in subsection (2)(b) of this section shall:
(a) Describe the deficiency in detail; and
(b) Identify a specific action to be taken by the MCO to correct the deficiency, including a time frame.

Section 15. Provider Access Requirements. (1) The access standards requirements established in 42 C.F.R. 438.206 through 438.210 shall apply to an MCO.
(2) An MCO shall make available and accessible to an enrollee:
(a) Facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section;
(b) Emergency medical services twenty-four (24) hours a day, seven (7) days a week; and
(c) Urgent care services within 48 hours of request.
(3)(a) An MCO's primary care provider delivery site shall be no more than:
1. Thirty (30) miles or thirty (30) minutes from an enrollee's residence or place of employment in an urban area; or
2. Forty-five (45) miles or forty-five (45) minutes from an enrollee's residence or place of employment in a non-urban area.
(b) An MCO's primary care provider shall not have an enrollee to primary care provider ratio greater than 1,500:1.
(c) An appointment wait time at an MCO's primary care delivery site shall not exceed:
1. Thirty (30) days from the date of an enrollee's request for a routine or preventive service; or
2. Forty-eight (48) hours from an enrollee's request for urgent care.
(4)(a) An appointment wait time for a specialist, except for a specialist providing a behavioral health service as provided in paragraph (b) of this subsection, shall not exceed:
1. Thirty (30) days from the referral for routine care; or
2. Forty-eight (48) hours from the referral for urgent care.
(b) A behavioral health service requiring crisis stabilization shall be provided within twenty-four (24) hours of the referral.
2. Behavioral health urgent care shall be provided within forty-eight (48) hours of the referral.
3. A behavioral health service appointment following a discharge from an acute psychiatric hospital shall occur within fourteen (14) days of discharge.
4. A behavioral health service appointment not included in subparagraph 1, 2, or 3 of this paragraph shall occur within sixty (60) days of the referral.
(5) An MCO shall have:
1. Specialists available for the subpopulations designated in Section 30 of this administrative regulation; and
2. Sufficient pediatric specialists to meet the needs of enrollees who are less than twenty-one (21) years of age.
(6) An emergency service shall be provided at a health care facility most suitable for the type of injury, illness, or condition, whether or not the facility is in the MCO network.
(7)(a) Except as provided in paragraph (b) of this subsection, an enrollee's transport time to a hospital shall not exceed thirty (30) minutes from an enrollee's residence.
(b) Transport-time to a hospital shall not exceed sixty (60) minutes from an enrollee's residence:
1. In a rural area; or
2. For a behavioral or physical rehabilitation service.
(8)(a) Transport time for a dental service shall not exceed one (1) hour from an enrollee's residence.
(b) A dental appointment wait time shall not exceed:
1. Three (3) weeks for a regular appointment; or
2. Forty-eight (48) hours for urgent care.
(9)(a) Transport time to a general vision, laboratory, or radiological service shall not exceed one (1) hour from an enrollee's residence.
(b) A general vision, laboratory, or radiological appointment wait time shall not exceed:
1. Three (3) weeks for a regular appointment; or
2. Forty-eight (48) hours for urgent care.
(10)(a) Transport time to a pharmacy service shall not exceed one (1) hour from an enrollee's residence.
(b) A pharmacy delivery site, except for a mail order pharmacy, shall not be further than fifty (50) miles from an enrollee's residence.
(c) Transport time or distance threshold shall not apply to a mail-order pharmacy except that it shall:
1. Be physically located within the United States of America; and
2. Provide delivery to the enrollee's residence.
(11)(a) Prior authorization shall not be required for a physical emergency service or a behavioral health emergency service.
(b) In order to be covered, an emergency service shall be:
1. Medically necessary; and
2. Authorized after being provided if the service was not prior authorized; and
3. Covered in accordance with Section 29(1) of this administra-
Section 16. Provider Manual. (1) An MCO shall provide a provider manual to a provider within five (5) working days of enrollment with the MCO. (2) Prior to distributing a provider manual or update to a provider manual, an MCO shall procure the department's approval of the provider manual or provider manual update. (3) The provider manual shall be available in hard copy and on the MCO's website.

Section 17. Provider Orientation and Education. An MCO shall: (1) Conduct an initial orientation for a provider within thirty (30) days of enrollment with the MCO to include: (a) Medicaid coverage policies and procedures; (b) Reporting fraud and abuse; (c) Medicaid eligibility groups; (d) The standards for preventive health services; (e) The special needs of enrollees; (f) Advance medical directives; (g) EPSDT services; (h) Claims submission; (i) Core management or disease management programs available to enrollees; (j) Cultural sensitivity; (k) The needs of enrollees with mental, developmental, or physical disabilities; (l) The reporting of communicable diseases; (m) The MCO's OAPI program as referenced in Section 48 of this administrative regulation; (n) Medical records; (o) The external quality review organization; and (p) The rights and responsibilities of enrollees and providers; and (2) Ensure that a provider: (a) Is informed of an update on a federal, state, or contractual requirement; (b) Receives education on a finding from its OAPI program if deemed necessary by the MCO or department; and (c) Makes available to the department training attendance roster that shall be dated and signed by the attendees.

Section 18. Provider Credentialing and Recredentialing. (1) An MCO shall: (a) Have policies and procedures that comply with 907 KAR 1:672, KRS 205.560, and 42 C.F.R. 455.400 to 455.420, regarding the credentialing and recredentialing of a provider; (b) Have a process for verifying a provider's credentials and malpractice insurance that shall include: 1. Written policies and procedures for credentialing and recredentialing of a provider; 2. A governing body, or a group or individual to whom the governing body has formally delegated the credentialing function; and 3. A review of the credentialing policies and procedures by the governing body or its delegate; (c) Have a credentialing committee that makes recommendations regarding credentialing; (d) If a provider requires a review by the credentialing committee, based on the MCO's quality criteria, notify the department of the facts and outcomes of the review; (e) Have written policies and procedures for: 1. Excluding, terminating, or suspending a provider; and 2. Reporting a quality deficiency that results in an exclusion, suspension, or termination of a provider; (f) Document its monitoring of a provider; (g) Verify a provider's qualifications through a primary source that includes: 1. A current valid license or certificate to practice in the Commonwealth of Kentucky; 2. A Drug Enforcement Administration certificate and number, if applicable; 3. If a provider is not board certified, proof of graduation from a medical school and completion of a residency program; 4. Proof of completion of an accredited nursing, dental, physician assistant, or vision program, if applicable; 5. If a provider states on an application that the provider is board certified in a specialty, a professional board certification; 6. A previous five (5) year work history; 7. A professional liability claims history; 8. If a provider requires access to a hospital to practice, proof that the provider has clinical privileges and is in good standing at the hospital designated by the provider as the primary admitting hospital; 9. Malpractice insurance; 10. Documentation, if applicable, of a: a. Revocation, suspension, or probation of a state license or Drug Enforcement Agency certificate and number; b. Curtailment or suspension of a medical staff privilege; c. Sanction or penalty imposed by the United States Department of Health and Human Services or a state Medicaid agency; or d. Censure by a state or county professional association; and (h) The most recent provider information available from the National Practitioner Data Bank; (h) Obtain access to the National Practitioner Data Bank as part of its credentialing process; (i) Have: 1. A process to recredential a provider at least once every three (3) years that shall be in accordance with subsection (3) of this section; and 2. Procedures for monitoring a provider sanction, a complaint, or a quality issue between a recredentialing cycle; (j) Have or obtain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line within four (4) years of implementation of this administrative regulation; and (k) Continuously maintain NCQA accreditation for its Medicaid product line after obtaining the accreditation.

(2) If an MCO subcontracts a credentialing or recredentialing function, the MCO and the subcontractor shall have written policies and procedures for credentialing and recredentialing.

(3) A provider shall complete a credentialing application in accordance with 907 KAR 1:672, that includes a statement by the provider regarding: (a) The provider's ability to perform essential functions of a position, with or without accommodation; (b) The provider's lack of current illegal drug use; (c) The provider's history of: 1. Loss of license or a felony conviction; 2. Loss or limitation of a privilege; or 3. Disciplinary action; (d) A sanction, suspension, or termination by the United States Department of Health and Human Services or a state Medicaid agency; (e) Clinical privileges and standing at a hospital designated as the primary admitting hospital of the provider; (f) Malpractice insurance maintained by the provider; and (g) The correctness and completeness of the application.

(4) The department shall be responsible for credentialing and recredentialing a hospital-based provider.

Section 19. MCO Provider Enrollment. (1) A provider enrolled with an MCO shall: (a) Be credentialed by the MCO in accordance with the standards established in Section 18 of this administrative regulation; and (b) Be eligible to enroll with the Kentucky Medicaid Program in accordance with 907 KAR 1:672. (2) An MCO shall: (a) Not enroll a provider in its network if: 1. The provider has an active sanction imposed by the Centers for Medicare and Medicaid Services or a state Medicaid agency; 2. A required provider license or a certification is not current; 3. Based on information or records available to the MCO: a. The provider owes money to the Kentucky Medicaid program; or b. The Kentucky Office of the Attorney General has an active fraud investigation of the provider; or 4. The provider is not credentialed;
Section 20. Provider Discrimination. An MCO shall:

(1) Comply with the antidiscrimination requirements established in:
   (a) 42 U.S.C. § 1396u-2(b)(7);
   (b) 42 C.F.R. § 438.12; and
   (c) KRS 304.17A-270; and

(2) Provide written notice to a provider denied participation in
   the MCO’s network stating the reason for the denial.

Section 21. Release for Ethical Reasons. An MCO shall:

(1) Not require a provider to perform a treatment or procedure that
   is contrary to the provider’s conscience, religious beliefs, or
   ethical principles in accordance with 42 C.F.R. § 438.102;

(2) Not prohibit or restrict a provider from advising an enrollee
   about health status, medical care, or a treatment;

(a) Whether or not coverage is provided by the MCO; and

(b) If the provider is acting within the lawful scope of practice;

(3) Have a referral process in place if a provider declines to
   perform a service because of an ethical reason.

Section 22. Provider Grievances and Appeals. (1) An MCO shall
have written policies and procedures for the filing of a provid-
er grievance or appeal.

(2) A provider shall have the right to:
   (A) A grievance with an MCO;
   (B) An appeal with an MCO regarding:
      1. A provider payment issue; or
      2. A contractual issue.

(3)(a) A provider grievance or appeal shall be resolved within
     thirty (30) calendar days.

(b) If a grievance or appeal is not resolved within thirty (30)
     days, an MCO shall request a fourteen (14) day extension from the
     provider. The provider shall comply or disapprove the extension.

(c) If a provider requests an extension, the MCO shall approve
     the extension.

Section 23. Cost Reporting Information. The department shall
provide to the MCO the calculation of Medicaid allowable co-
tests used in the Medicaid Program.

Section 24. Medical Records. (1) An MCO shall:

(a) Require a provider to maintain an enrollee medical record on
    paper or in an electronic format; and

(b) Have a process to systematically review provider medical
    records to ensure compliance with the medical records standards
    established in this section.

(2) An enrollee medical record shall:

(a) Be legible, current, detailed, organized, and signed by the
    provider;

(b) Be kept for at least five (5) years from the date of service;
    unless a federal statute or regulation requires a longer retention
    period; and

2. If a federal statute or regulation requires a retention period
    longer than five (5) years, be kept for at least as long as the fede-
    rally required retention period;

(c) Include the following minimal detail for an individual clinical
    encounter:

   1. The history and physical examination for the presenting
      complaint;
   2. A psychological or social factor affecting the patient’s physi-
      cal or behavioral health;
   3. An unresolved problem, referral, or result from a diagnostic

   test; and

4. The plan of treatment including:

   a. Medication history, medications prescribed, including the
      strength, amount, and directions for use and refills;

   b. Therapy or other prescribed regimen; and

   c. Follow-up plans, including consultation, referrals, and return
      appointment.

(3) A medical chart organization and documentation shall, at
    a minimum, contain the following:

(a) Enrollee identification information on each page;

(b) Enrollee date of birth, age, gender, marital status, race or
    ethnicity, mailing address, home and work addresses, and tele-
    phone numbers (if applicable), employer (if applicable), school (if
    applicable), name and telephone number of an emergency contact,
    consent form, language spoken and guardianship information (if
    applicable);

(c) Date of data entry and of the encounter;

(d) Provider’s name;

(e) Any known allergies or adverse reactions of the enrollee;

(f) Enrollee’s past medical history;

(g) Documentation of notification of reportable diseases and
    conditions to the local health department serving the jurisdiction
    in which the enrollee resides or to the Department for Public Health
    pursuant to 902 KAR 2:020;

(i) Follow-up visits provided secondary to reports of emergency
    room care;

(m) Hospital discharge summaries;

(n) Advance medical directives for adults; and

(o) All written denials of service and the reason for each denial.

Section 25. Confidentiality of Medical Information. (1) An MCO
shall:

(a) Maintain confidentiality of all enrollee eligibility information
    and medical records;

(b) Prevent unauthorized disclosure of the information ref-
    erenced in this subsection in accordance with 42 U.S.C. 1320d-2,
    42 C.F.R. § 431.300 to 431.307; and

(c) Have written policies and procedures for maintaining the
    confidentiality of enrollee records;

(d) Comply with 42 U.S.C. § 1320d-2, the Health Insurance Po-
    tability and Accountability Act, and 45 C.F.R. Parts 160 and 164;

(e) On behalf of its employees and agents:

   1. Sign a confidentiality agreement attesting that it will comply
      with the confidentiality requirements established in this section;

   2. Submit the confidentiality agreement referenced in subpara-
      graph 1. of this paragraph to the department;

(2) Limit access to medical information to a person or agency
which requires the information in order to perform a duty related to
the department’s administration of the Medicaid program, including
the department, the United States Department of Health and Hu-
man Services, the United States Attorney General, the CHFS OIG,
the Kentucky Attorney General, or other agency required by the
department, and

(g) Submit a request for disclosure of information referenced in
    this subsection which has been received by the MCO to the de-
    partment within twenty-four (24) hours.

2. Information referenced in subsection (1)(g) of this section
shall not be disclosed by an MCO pursuant to the request without
prior written authorization from the department.

Section 26. Americans with Disabilities Act and Cabinet Omb-
udsman. (1) An MCO shall:

(a) Require by contract with its network providers and subco-
    ntractors that a service location meets:

   1. The requirements established in 42 U.S.C. Chapter 126, the
Americans with Disabilities Act; and

2. All local requirements which apply to health facilities pertaining to adequate space, supplies, sanitation, and fire and safety procedures;

(b) Fully cooperate with the Cabinet for Health and Family Services independent ombudsman; and

(c) Provide immediate access to the Cabinet for Health and Family Services independent ombudsman to an enrollee’s records if the enrollee has given consent.

(2) An MCO’s member handbook shall contain information regarding the Cabinet for Health and Family Services independent ombudsman program.

Section 27. Marketing. (1) An MCO shall:

(a) Comply with the requirements established in 42 C.F.R. 438.104 regarding marketing activities;

(b) Have a system of control over the content, form, and method of dissemination of its marketing and information materials; and

(c) Submit a marketing plan and marketing materials to the department for written approval prior to implementation or distribution.

(d) If conducting mass media marketing, direct the marketing activities to enrollees in the entire service area pursuant to the marketing plan;

(e) Not use fraudulent, misleading, or misrepresentative information in its marketing materials;

(f) Not offer material or financial gain to a:

1. Potential enrollee as an inducement to select a particular provider or use a product or;

2. Person for the purpose of soliciting, referring, or otherwise facilitating the enrollment of an enrollee;

(g) Not conduct:

1. Direct telephone marketing to enrollees or potential enrollees who do not reside in the MCO service area;

2. Direct or indirect door-to-door, telephone, or other cold-call marketing activity; and

(i) Not include in its marketing materials an assertion or statement that CMS, the federal government, the Commonwealth, or another entity endorses the MCO.

(2) An MCO’s material shall meet the information requirements established in Section 12 of this administrative regulation.

Section 28. MCO Service Areas. (1)(a) An MCO’s service areas shall include regions one (1), two (2), four (4), five (5), six (6), seven (7), and eight (8).

(b) An MCO’s service areas shall not include region three (3).

(2) A recipient who is eligible for enrollment with a managed care organization and who resides in region three (3) shall receive services in accordance with 907 KAR 1:705.

(3) Region one (1) shall include the following counties:

(a) Ballard;

(b) Caldwell;

(c) Calloway;

(d) Carlisle;

(e) Crittenden;

(f) Fulton;

(g) Graves;

(h) Hickman;

(i) Livingston;

(j) Lyon;

(k) Marshall; and

(l) McCracken.

(4) Region two (2) shall include the following counties:

(a) Christian;

(b) Daviess;

(c) Hancock;

(d) Henderson;

(e) Hopkins;

(f) McLean;

(g) Muhlenberg;

(h) Ohio;

(i) Trigg;

(j) Todd;

(k) Union; and

(l) Webster.

(5) Region three (3) shall include the following counties:

(a) Bracken;

(b) Bullitt;

(c) Carroll;

(d) Grayson;

(e) Hardin;

(f) Henry;

(g) Jefferson;

(h) Larue;

(i) Marion;

(j) Meade;

(k) Nelson;

(l) Oldham;

(m) Shelby;

(n) Spencer;

(o) Trimble; and

(p) Washington.

(6) Region four (4) shall include the following counties:

(a) Adair;

(b) Allen;

(c) Barren;

(d) Butler;

(e) Casey;

(f) Clinton;

(g) Cumberland;

(h) Edmonson;

(i) Green;

(j) Hart;

(k) Logan;

(l) McCracken;

(m) Metcalfe;

(n) Monroe;

(o) Pulaski;

(p) Russell;

(q) Simpson;

(r) Taylor;

(s) Warren; and

(t) Wayne.

(7) Region five (5) shall include the following counties:

(a) Anderson;

(b) Bourbon;

(c) Boyle;

(d) Clark;

(e) Estill;

(f) Fayette;

(g) Fleming;

(h) Garrard;

(i) Harrison; and

(j) Jessamine;

(k) Jessamine;

(l) Lincoln;

(m) Madison;

(n) Mercer;

(o) Montgomery;

(p) Nicholas;

(q) Owen;

(r) Powell;

(s) Rockcastle;

(t) Scott; and

(u) Woodford.

(8) Region six (6) shall include the following counties:

(a) Boone;

(b) Campbell;

(c) Gallatin;

(d) Grant;

(e) Kenton; and

(f) Pendleton.

(9) Region seven (7) shall include the following counties:

(a) Bath;
Section 29. Covered Services. (1) Except as established in subsection (2) of this section, an MCO shall be responsible for the provision and costs of a covered health service:

(a) Established in Title 907 of the Kentucky Administrative Regulations;

(b) In the amount, duration, and scope that the services are covered for recipients pursuant to the department’s administrative regulations located in Title 907 of the Kentucky Administrative Regulations; and

(c) Beginning on the date of enrollment of a recipient into the MCO.

(2) Other than a nursing facility cost referenced in subsection (3)(i) of this section, an MCO shall be responsible for the cost of a non-nursing facility covered service provided to an enrollee during the first thirty (30) days of a nursing facility admission in accordance with this administrative regulation.

(3) An MCO shall not be responsible for the provision or costs of the following:

(a) A service provided to a recipient in an intermediate care facility for individuals with mental retardation or a developmental disability;

(b) A service provided to a recipient in a 1915(c) home and community-based waiver program;

(c) A hospice service provided to a recipient in an institution;

(d) A nonemergency transportation service provided in accordance with 907 KAR 3:066;

(e) An emergency service;

(f) A screening, evaluation, or treatment service for a sexually transmitted disease or tuberculosis;

(g) Testing for HIV, HIV-related condition, or other communicable disease; and

(h) A chiropractic service.

(a)1. Develop materials specific to the needs of an enrollee with a special health care need:

(b) By the enrollee’s primary care provider, or

(c) An evaluation by an orthodontist or a prosthodontist;

(d) A service provided by a women’s health specialist;

(e) A family planning service;

(f) Maternity care for an enrollee under age eighteen (18);

(g) An immunization for an enrollee under twenty-one (21);

(h) A nursing facility service for an enrollee during the first thirty (30) days of a nursing facility admission.

Section 30. Enrollees with Special Health Care Needs. (1) In accordance with 42 U.S.C. 1396u-2(b)(2)(A)(i), compliance with paragraph (a) of this subsection is required:

(a) The following shall be considered an individual with a special health care need:

1. A child in or receiving foster care or adoption assistance;

2. A homeless individual;

3. An individual with a chronic physical or behavioral illness;

4. A blind or disabled child;

5. An individual who is eligible for SSI benefits; or

6. An adult who is a ward of the Commonwealth in accordance with 910 KAR Chapter 2; and

(b) An MCO shall:

1. Have a process to target enrollees for the purpose of screening and identifying those with special health care needs;

2. Assess each enrollee identified by the department as having a special health care need to determine if the enrollee needs case management or regular care monitoring;

3. Include the use of appropriate health care professionals to perform an assessment; and

(c) Be responsible for the ongoing care coordination for an enrollee with a special health care need.
(A) An MCO shall provide an enrollee with a health care plan that shall be completed for the enrollee by DBCS prior to being enrolled with the MCO.

(b) The service plan referenced in paragraph (a) of this subsection shall be used by DBCS and the MCO to determine the enrollee's needs and identify the need for case management.

(c) The MCO shall be responsible for a service referenced in subsection (3)(a) of this section.

(d) If a service plan identifies the need for case management or DBCS requests case management for an enrollee, the foster parent of the child or DBCS shall work with the MCO to develop a case management plan of care.

(e) The MCO shall consult with DBCS prior to developing or modifying a case management plan of care.

(f)(a) An enrollee who is a ward of the Commonwealth shall be enrolled with an MCO through a service plan that shall be complete for the enrollee by DBCS prior to being enrolled with the MCO.

(b) If the service plan referenced in paragraph (a) of this subsection identifies the need for case management, the MCO shall work with DBCS or the enrollee to develop a case management plan of care.

Section 31. Second Opinion. An enrollee shall have the right to a second opinion within the MCO's provider network for a surgical procedure or diagnosis and treatment of a complex or chronic condition.

Section 32. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. (1) An MCO shall provide an enrollee under the age of twenty-one (21) years with EPSDT services in compliance with:

(a) 907 KAR 11:034;
(b) 45 U.S.C. 1396d(f); and
(c) The Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule.

(2) A provider of an EPSDT service shall meet the requirements established in 907 KAR 11:034.

Section 33. Emergency Care, Urgent Care, and Poststabilization Care. (1) An MCO shall provide to an enrollee:

(a) Emergency care twenty-four (24) hours a day, seven (7) days a week; and
(b) Urgent care within forty-eight (48) hours.

(2) Poststabilization services shall be provided and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e).

Section 34. Maternity Care. An MCO shall:

(1) Have procedures to assure:

(a) Prompt initiation of prenatal care; or
(b) Continuation of prenatal care without interruption for a woman who is pregnant at the time of enrollment;

(2) Provide maternity care that includes:

(a) Prenatal care;
(b) Delivery;
(c) Postpartum care; and
(d) Care for a condition that complicates a pregnancy; and

(3) Perform all the newborn screenings referenced in 902 KAR 4:030.

Section 35. Pediatric Interface. (1) An MCO shall:

(a) Have procedures to coordinate care for a child receiving a school-based health service or an early intervention service; and

(b) Monitor the continuity and coordination of care for the child receiving a service referenced in paragraph (a) of this subsection as part of its quality assessment and performance improvement (QAPI) program established in Section 48 of this administrative regulation.

(2) Except when a child's course of treatment is interrupted by a school break, after school hours, or summer break, an MCO shall not be responsible for a service referenced in subsection (1)(a) of this section.

(3) A school-based health service provided by a school district shall not be covered by an MCO.

(4) A school-based health service provided by a local health department shall be covered by an MCO.

Section 36. Pediatric Sexual Abuse Examination. (1) An MCO shall enroll at least one (1) provider in its network who has the capacity to perform a forensic pediatric sexual abuse examination.

(2) A forensic pediatric sexual abuse examination shall be conducted for an enrollee at the request of the DCBS.

Section 37. Lock-in Program. (1) An MCO shall have a program to control utilization of:

(a) Drugs and other pharmacy benefits; and

(b) Non-emergency care provided in an emergency setting.

(2) The program referenced in subsection (1) of this section shall be:

(a) Approved by the department; and

(b) In accordance with 907 KAR 1:677.

Section 38. Pharmacy Benefit Program. (1) An MCO shall:

(a) Have a pharmacy benefit program that shall have:

1. A point-of-sale claims processing service;

2. Prospective drug utilization review;

3. An accounts receivable process;

4. Retrospective utilization review services;

5. Formulary and non-formulary drugs;

6. A prior authorization process for drugs;

7. Pharmacy provider relations;

8. A toll-free call center that shall respond to a pharmacy or a physician prescriber twenty-four (24) hours a day, seven (7) days a week; and

9. A seamless interface with the department's management information system;

(b) Maintain a preferred drug list (PDL);

(c) Have a pharmacy benefit program that shall:

1. Provide the following to an enrollee or a provider:

   1. PDL information; and

   2. Pharmacy cost sharing information; and

2. Have a Pharmacy and Therapeutics Committee (P&T Committee), which shall:

   1. Meet periodically throughout the calendar year as necessary; and

   2. Make recommendations to the MCO for changes to the drug formulary.

3) The department shall comply with the drug rebate collection requirement established in 42 U.S.C. 1396b(m)(2)(A)(xiii).

(b) An MCO shall:

1. Cooperate with the department in complying with 42 U.S.C. 1396b(m)(2)(A)(xiii);

2. Assist the department in resolving a drug rebate dispute with a manufacturer; and

3. Be responsible for drug rebate administration in a non-pharmacy setting.

(3) An MCO's P&T committee shall meet and make recommendations to the MCO for changes to the drug formulary.

(4) If a prescription for an enrollee is for a preferred drug and the pharmacist cannot reach the enrollee's primary care provider or the MCO for approval and the pharmacist determines it necessary to provide the prescribed drug, the pharmacist shall:

(a) Provide a seventy-two (72) hour supply of the prescribed drug; or

(b) Provide less than a seventy-two (72) hour supply of the prescribed drug, if the request is for less than a seventy-two (72) hour supply.

(5) Cost sharing imposed by an MCO shall not exceed the cost sharing limits established in 907 KAR 1:604.

Section 39. MCO Interface with the Department Regarding Behavioral Health. An MCO shall:
(1) Meet with the department monthly to discuss:
   (a) Serious mental illness and serious emotional disturbance operating definitions;
   (b) Priority populations; and
   (c) Targeted case management and peer support provider certification training and processes;

(2) IMPACT Plus program operations;
   (a) Satisfaction survey requirements;
   (b) Priority training topics;
   (c) Behavioral health services hotline; or
   (d) Behavioral health crisis services;

(3) Coordinate:
   (a) An IMPACT Plus covered service provided to an enrollee in accordance with 907 KAR 3:030;
   (b) With the department:
      1. An enrollee education process for:
         a. Individuals with a serious mental illness; and
         b. Children or youth with a serious emotional disturbance; and
      2. Establish a collaborative agreement with a:
         a. State-operated or state-contracted psychiatric hospital; and
         b. Facility that provides a service to an individual with a co-occurring behavioral health and developmental and intellectual disabilities; and
   (c) With the department and community mental health centers a process for integrating a behavioral health service hotline; and
   (d) Provide the department with proposed materials and protocols for the enrollee education referenced in subsection (2)(b) of this section.

Section 40. Behavioral Health Services. (1) An MCO shall:
   (a) Provide a medically necessary behavioral health service to an enrollee in accordance with the access standards established in section 5 of this chapter;
   (b) Use the DSM-IV multi-axial classification system to assess an enrollee for a behavioral service;
   (c) Have an emergency or crisis behavioral health toll-free hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week;
   (d) Not operate one (1) hotline to handle both an emergency or crisis call and a routine enrollee call; and
   (e) Not impose a daily or duration limit.

Section 15. Section 41. Coordination Between a Behavioral Health Provider and a Primary Care Provider. (1) An MCO shall:
   (a) Require a PCP to have a screening and evaluation procedure for the detection and treatment of, or referral for, a known or suspected behavioral health problem or disorder;
   (b) Provide training to a PCP in its network on:
      1. Screening and evaluating a behavioral health disorder;
      2. The MCO’s referral process for a behavioral health service; and
      3. Coordination requirements for a behavioral health provider;
   and
   (c) Have policies and procedures that shall be approved by the department regarding clinical coordination between a behavioral health service provider and a PCP;
   (d) Establish guidelines and procedures to ensure accessibility, availability, referral, and triage to physical and behavioral health care;
   (e) Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;
   (f) Identify a method to evaluate continuity and coordination of care; and
   (g) Include the monitoring and evaluation of the MCO’s compliance with the requirements established in paragraphs (a) to (f) of this subsection in the MCO’s quality improvement plan.

(3) With consent from an enrollee or the enrollee’s legal guardian, an MCO shall require a behavioral health service provider to:
   (a) Refer an enrollee with a known or suspected and untreated physical health problem or disorder to their PCP for examination and treatment; and
   (b) Send an initial and quarterly summary report of an enrollee’s behavioral health status to the enrollee’s PCP.

Section 42. Court-Ordered Psychiatric Services. (1) An MCO shall:
   (a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-one (21) and over the age of sixty-five (65) who has been ordered to receive the service by a court of competent jurisdiction under the provisions of KRS Chapters 202A and 645;
   (b) Not deny, reduce, or negate the medical necessity of an inpatient psychiatric service provided pursuant to a court-ordered commitment for an enrollee under the age of twenty-one (21) or over the age of sixty-five (65);
   (c) Coordinate with a provider of a behavioral health service the treatment objectives and projected length of stay for an enrollee committed by a court of law to a state psychiatric hospital; and
   (d) Enter into a collaborative agreement with the state-operated or state-contracted psychiatric hospital assigned to the enrollee’s region in accordance with 905 KAR 3:040 and in accordance with the Olmstead decision.

(2) An MCO shall present a modification or termination of a service referenced in subsection (1)(b) of this section to the court with jurisdiction over the matter for determination.

Section 43. Legal Guardians. (1) A parent, custodial parent, person exercising custodial control or supervision, or an agency with a legal responsibility for a child by virtue of a voluntary commitment or of an emergency or temporary custody order shall be authorized to act on behalf of an enrollee who is under the age of eighteen (18) years, a potential enrollee, or a former enrollee for the purpose of:
   (a) Selecting a primary care provider;
   (b) Filing a grievance or appeal; and
   (c) Taking an action on behalf of the child regarding an interaction with an MCO.

(2)(a) A legal guardian who has been appointed pursuant to KRS 387.500 to 387.800 shall be allowed to act on behalf of an enrollee who is a ward of the commonwealth.
   (b) A person authorized to make a health care decision pursuant to KRS 311.661 to 311.664 shall be allowed to act on behalf of an enrollee, potential enrollee, or former enrollee.
   (c) An enrollee shall have the right to:
      1. Represent the enrollee; or
      2. Use legal counsel, a relative, a friend, or other spokesperson.

Section 44. Utilization Management or UM. (1) An MCO shall:
   (a) Have a utilization management program that shall:
      1. Meet the requirements established in 42 C.F.R. Parts 431, 438, and 456, and the private review agent requirements of KRS 304.17A; and
      2. Identify, define, and specify the amount, duration, and scope
of each service that the MCO is required to offer;
3. Review, monitor, and evaluate the appropriateness and medical necessity of care and services;
4. Identify and describe the UM mechanisms used to:
   a. Detect the under- or over-utilization of services; and
   b. Act after identifying under- or over-utilization of services;
5. Have a written UM program description in accordance with subsection (2) of this section; and
   b. Be evaluated annually by the:
      a. MCO, including an evaluation of clinical and service outcomes; and
      b. Department;
   (b) Adopt nationally recognized standards of care and written criteria that shall be:
      1. Based upon sound clinical evidence, if available, for making utilization decisions; and
      2. Approved by the department;
   (c) Include the:
      1. The initial decision was not in writing; and
      2. Requested
   (d) If the service
   (e) Submit a request for a change in review criteria and establish a written policy and procedure, which includes a timeframe for:
      (a) Making an authorization decision; and
      (b) If the service is denied or authorized in an amount, duration, or scope which is less than requested, providing a notice to the enrollee and provider acting on behalf of and with the consent of an enrollee.
   (f) For an authorization of a service, an MCO shall make a decision:
      (a) As expeditiously as the enrollee’s health condition requires; and
      (b) Within two (2) business days following receipt of a request for service.
   (3) The timeframe for making an authorization decision referenced in subsection (2) of this section may be extended:
      (a) By the:
         1. Enrollee, or the provider acting on behalf of and with consent of an enrollee, if the enrollee requests an extension; or
         2. MCO, if the MCO:
            a. Justifies to the department, upon request, a need for additional information and how the extension is in the enrollee’s interest;
            b. Gives the enrollee written notice of the extension, including the reason for extending the authorization decision timeframe and the right of the enrollee to file a grievance if the enrollee disagrees with that decision; and
            c. Makes and carries out the authorization decision as expeditiously as the enrollee’s health condition requires and no later than the date the extension expires; and
      (4) If an MCO denies a service authorization or authorizes a service in an amount, duration, or scope which is less than requested, the MCO shall provide a notice:
         (a) To the:
            1. Enrollee, in writing, as expeditiously as the enrollee’s condition requires and within two (2) business days of receipt of the request for service; and
            2. Requesting provider, if applicable;
         (b) Which shall:
            1. Meet the language and formatting requirements established in 42 C.F.R. 438.404;
            2. Include that:
               a. Action the MCO or its subcontractor, if applicable, has taken or intends to take;
               b. Reason for the action;
               c. Right of the enrollee or provider who is acting on behalf of the enrollee to file an MCO appeal;
               d. Right of the enrollee to request a state fair hearing;
               e. Procedure for filing an appeal and requesting a state fair hearing;
               f. Circumstance under which an expedited resolution is available and how to request it; and
               g. Right to have benefits continue pending resolution of the appeal; how to request that benefits be continued, and the circumstance under which the enrollee may be required to pay the costs of these services; and
         3. Be provided:
            a. At least ten (10) days before the date of action if the action is a termination, suspension, or reduction of a covered service authorized by the department, department designee, or enrollee’s MCO, except the department may shorten the period of advance notice to five (5) days before the date of action because of probable fraud by the enrollee;
Section 45. Quality Assessment and Performance Improvement (QAPI) Program. An MCO shall:

(1) Have a quality assessment and performance improvement (QAPI) program that shall:
   (a) Conform to the requirements of 42 C.F.R. 438 Subpart D, 438.200 to 438.242;
   (b) Assess, monitor, evaluate, and improve the quality of care provided to an enrollee;
   (c) Be developed in collaboration with input from enrollees;
   (d) Be developed in collaboration with enrollee representatives;
   (e) Be developed in collaboration with the Quality Improvement Committee;
   (f) Be developed in collaboration with other quality improvement committees;
   (g) Be developed in collaboration with the MCO's medical directors;
   (h) Be developed in collaboration with other medical directors;
   (i) Be developed in collaboration with the MCO's clinical directors;
   (j) Be developed in collaboration with other clinical directors;
   (k) Be developed in collaboration with the MCO's administrative directors;
   (l) Be developed in collaboration with other administrative directors;
   (m) Be developed in collaboration with the MCO's financial directors;
   (n) Be developed in collaboration with other financial directors;
   (o) Be developed in collaboration with the MCO's information technology directors;
   (p) Be developed in collaboration with other information technology directors;
   (q) Be developed in collaboration with the MCO's legal directors;
   (r) Be developed in collaboration with other legal directors;
   (s) Be developed in collaboration with the MCO's compliance directors;
   (t) Be developed in collaboration with other compliance directors;
   (u) Be developed in collaboration with the MCO's human resources directors;
   (v) Be developed in collaboration with other human resources directors;
   (w) Be developed in collaboration with the MCO's finance directors;
   (x) Be developed in collaboration with other finance directors;
   (y) Be developed in collaboration with the MCO's human resources directors;
   (z) Be developed in collaboration with other human resources directors;
   (aa) Be developed in collaboration with the MCO's legal directors;
   (bb) Be developed in collaboration with other legal directors;
   (cc) Be developed in collaboration with the MCO's compliance directors;
   (dd) Be developed in collaboration with other compliance directors;
   (ee) Be developed in collaboration with the MCO's human resources directors;
   (ff) Be developed in collaboration with other human resources directors;
   (gg) Be developed in collaboration with the MCO's finance directors;
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   (hhh) Be developed in collaboration with other human resources directors;
   (iii) Be developed in collaboration with the MCO's finance directors;
   (jjj) Be developed in collaboration with other finance directors;
   (kkk) Be developed in collaboration with the MCO's human resources directors;
referred in paragraph (h) of this subsection; (i) Review its QAPI program annually; (j) Modify its QAPI program to accommodate a review finding or concern of the MCO if a review finding or concern occurs; (k) Have a quality improvement committee that shall: 1. Be responsible for the QAPI program; 2. Be interdisciplinary; 3. Include: a. Providers and administrative staff; and b. Health professionals with knowledge of and experience with individuals with special health care needs; 4. Meet on a regular basis; 5. Document activities of the committee; 6. Make committee minutes and a committee report available to the department upon request; and 7. Submit a report to the accountable entity referenced in paragraph (e) of this subsection that shall include: a. A description of the QAPI activities; b. Progress on objectives; and c. Improvements made; (l) Require a provider to participate in QAPI activities in the provider agreement or subcontract; and (m) Provide feedback to a provider or subcontractor regarding integration of or operation of a corrective action necessary in a QAPI activity if a corrective action is necessary. (2) If a QAPI activity of a provider or subcontractor is separate from an MCO’s QAPI program, the activity shall be integrated into the MCO’s QAPI program.

Section 50. QAPI Monitoring and Evaluation. (1) Through its QAPI program, an MCO shall: (a) Monitor and evaluate the quality of health care provided to an enrollee; (b) Study and prioritize health care needs for performance measurement, performance improvement, and development of practice guidelines; (c) Use a standardized quality indicator: 1. To assess improvement, assure achievement of at least a minimum performance level, monitor adherence to a guideline, and identify a pattern of over and utilization of a service; and 2. Which shall be: a. Supported by a valid data collection and analysis method; and b. Used to improve clinical care and services; (d) Measure a provider’s performance against a practice guideline and a standard adopted by the quality improvement committee; (e) Use a multidisciplinary team to analyze and address data and systems issues; and (f) Have practice guidelines that shall: 1. Be: a. Disseminated to a provider, or upon request, to an enrollee; b. Based on valid and reliable medical evidence or consensus of health professionals; c. Reviewed and updated; and d. Used by the MCO in making a decision regarding utilization management, a covered service, or enrollee education; 2. Consider the needs of enrollees; and 3. Include consultation with network providers. (2) If an area needing improvement is identified by the QAPI program, the MCO shall take a corrective action and monitor the corrective action for improvement.

Section 51. Quality and Member Access Committee. (1) An MCO shall: (a) Have a Quality and Member Access Committee (QMAC) composed of: 1. Enrollees who shall be representative of the enrollee population, and 2. Individuals from consumer advocacy groups or the community who represent the interests of enrollees in the MCO; and (b) Submit to the department annually a list of enrollee representatives participating in the QMAC. (2) A QMAC shall be responsible for reviewing: (a) Quality and access standards; (b) The grievance and appeals process; (c) Policy modifications needed based on reviewing aggregate grievance and appeals data; (d) The member handbook; (e) Enrollee education materials; (f) Community outreach activities; and (g) MCO and department policies that affect enrollees. (3) The QMAC shall provide the results of its reviews to the MCO.

Section 52. External Quality Review. (1) In accordance with 42 U.S.C. 1396a(a)(30), the department shall have an independent external quality review organization (EQRO) annually review the quality of services provided by an MCO. (2) An MCO shall: (a) Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Part 433, and 438; and (b) Cooperate and participate in external quality review activities in accordance with 42 C.F.R. 438.350. (3) The department shall have the option of using information from a Medicare or private accreditation review of an MCO in accordance with 42 C.F.R. 438.360.

Section 53. Health Care Outcomes. An MCO shall: (1) Comply with the requirements established in 42 C.F.R. 438.240 relating to quality assessment and performance improvement. (2) Collaborate with the department to establish a set of unique Kentucky Medicaid managed care performance measures which shall: (a) Be aligned with national and state preventive initiatives; and (b) Focus on improving health; (3) In collaboration with the department and the EQRO, develop a performance measure specific to individuals with special health care needs; (4) Report activities on performance measures in the QAPI work plan established in Section 49 of this administrative regulation; (5) Submit an annual report to the department after collecting performance data which shall be stratified by: (a) Medicaid eligibility category; (b) Race; (c) Ethnicity; (d) Gender; and (e) Age; (6) Collect and report HEDIS data annually; and (7) Submit to the department: (a) The final auditor’s report issued by the NCQA certified audit organization; (b) A copy of the interactive data submission system tool used by the MCO; and (c) The reports specified in MCO Reporting Requirements.

Section 54. Performance Improvement Projects (PIPs). (1) An MCO shall: (a) Implement PIPs to address aspects of clinical care and non-clinical services; (b) Collaborate with local health departments, behavioral health agencies, and other community-based health or social service agencies to achieve improvements in priority areas; (c) Initiate a minimum of two (2) PIPs each year with at least one (1) PIP relating to physical health and at least one (1) PIP relating to behavioral health; (d) Report on a PIP using standardized indicators; (e) Specify a minimum performance level for a PIP; and (f) Include the following for a PIP: 1. The topic and its importance to enrolled members; 2. Methodology for topic selection;
3. Goals of the PIP:
4. Data sources and collection methods;
5. An intervention; and
6. Results and interpretations.

(2) A clinical PIP shall address preventive and chronic health care needs of enrollees including:
(a) The enrollee population;
(b) A subpopulation of the enrollee population; and
(c) Specific clinical need of enrollees with conditions and illnesses that have a higher prevalence in the enrollee population.

(3) A non-clinical PIP shall address improving the quality, availability, and accessibility of services provided by an MCO to enrollees and providers.

(4) The department may require an MCO to implement a PIP specific to the MCO if:
(a) A finding from an EQRO review referenced in Section 52 of this administrative regulation or an audit indicates a need for a PIP; or
(b) Directed by CMS.

(5) The department shall be authorized to require an MCO to assist in a statewide PIP which shall be limited to providing the department with data from the MCO’s service area.

Section 55. Enrollee and Provider Surveys. (1) An MCO shall:
(a) Conduct an annual survey of enrollee and provider satisfaction with the quality and accessibility to a service provided by an MCO;
(b) Satisfy a member satisfaction survey requirement by participating in the Agency for Health Research and Quality’s current Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) for Medicaid Adults and Children, which shall be administered by an NCQA-certified survey vendor;
(c) Provide a copy of the results of the current CAHPS survey referenced in paragraph (b) of this subsection to the department;
(d) Annually assess the need for conducting other surveys to support quality and performance improvement initiatives; and
(e) Submit to the department for approval the survey tool used to conduct the survey referenced in paragraph (a) of this subsection; and
(f) Provide to the department:
1. A copy of the results of the enrollee and provider surveys referenced in paragraph (a) of this subsection;
2. A description of a methodology to be used to conduct surveys;
3. The number and percentage of enrollees and providers surveyed;
4. Enrollee and provider survey response rates;
5. Enrollee and provider survey findings; and
6. Interventions conducted or planned by the MCO related to activities in this section.

(2) The department shall:
(a) Approve enrollee and provider survey instruments prior to implementation; and
(b) Approve or disapprove an MCO’s provider survey tool within fifteen (15) days of receipt of the survey tool.

(3) If an MCO conducts a survey that targets a subpopulation’s perspective or experience with access, treatment, or services, the MCO shall comply with the requirements established in subsection (1)(e) and (f) of this section.

Section 56. Prompt Payment of Claims. (1) In accordance with 42 U.S.C. 1396b(a)(37), an MCO shall have prepayment and post-payment claims review procedures that ensure the proper and efficient payment of claims and management of the program.

(2) An MCO shall:
(a) Comply with the prompt payment provisions established in:
   1. 42 C.F.R. 447.45; and
   2. KRS 205.593, KRS 304.14-135, and KRS 304.17A-700 to 304.17A-730; and
(b) Notify a requesting provider of a decision to:
   1. Deny a claim; or
   2. Authorize a service in an amount, duration, or scope that is less than requested.

(3) The payment provisions in this section shall apply to a payment to:
(a) A provider within the MCO network; and
(b) An out-of-network provider.

Section 57. Payments to an MCO. (1) The department shall provide an MCO a per enrollee, per month capitation payment whether or not the enrollee receives a service during the period covered by the payment except for an enrollee whose eligibility is determined due to being unemployed in accordance with 45 C.F.R. 233.100.

(2) The monthly capitation payment for an enrollee whose eligibility is determined due to being unemployed shall be prorated from the date of eligibility.

(3) A capitation rate referenced in subsection (1) of this section shall:
(a) Meet the requirements of 42 C.F.R. 438.6(c); and
(b) Be approved by the Centers for Medicare and Medicaid Services.

(4) The department shall apply a risk adjustment to a capitation rate in an amount that shall be budget neutral to the department.

(5) The department shall use the latest version of the Chronic Illnesses and Disability Payment System to determine the risk adjustment referenced in paragraph (a) of this subsection.

Section 58. Recoupment of Payment from an Enrollee for Fraud, Waste, or Abuse. (1) If an enrollee is determined to be ineligible for Medicaid through an administrative hearing or adjudication of fraud by the CHFS OIG, the department shall recoup a capitation payment it has made to an MCO on behalf of the enrollee.

(2) An MCO shall request a refund from the enrollee referenced in subsection (1) of this section of the payment the MCO has made to the enrollee.

(3) If an MCO has been unable to collect a refund referenced in subsection (2) of this section within six (6) months, the Commonwealth shall have the right to recover the refund from the enrollee.

Section 59. MCO Administration. An MCO shall have executive management responsible for operations and functions of the MCO that shall include:
1. An executive director who shall:
   (a) Act as a liaison to the department regarding a contract between the MCO and the department;
   (b) Be authorized to represent the MCO regarding an inquiry pertaining to a contract between the MCO and the department;
   (c) Have decision making authority; and
   (d) Be responsible for following up regarding a contract inquiry or issue;
2. A medical director who shall be:
   (a) A physician licensed to practice medicine in Kentucky;
   (b) Actively involved in all major clinical programs and quality improvement components of the MCO; and
   (c) Available for after-hours consultation;
3. A dental director who shall be:
   (a) Licensed by a dental board of licensure in any state;
   (b) Actively involved in all oral health programs of the MCO; and
   (c) Available for after-hours consultation;
4. A finance officer who shall oversee the MCO’s budget and accounting systems; and
5. An external auditor who shall ensure compliance with adopted standards and review expenditures for reasonableness and necessity.

(5) A quality improvement director who shall be responsible for the operation of:
(a) The MCO’s quality improvement program; and
(b) A subcontractor’s quality improvement program;
6. A behavioral health director who shall be:
(a) A behavioral health practitioner;
(b) Actively involved in all of the MCO’s programs or initiatives relating to behavioral health; and
(c) Responsible for the coordination of behavioral health services provided by the MCO or any of its behavioral health subcon-
tractors;
(7) A care management coordinator who shall be responsible for coordinating and overseeing case management services and continuity of care for MCO enrollees;
(8) An early and periodic screening, diagnosis, and treatment (EPSDT) coordinator who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for MCO enrollees;
(9) A foster care and subsidized adoption care liaison who shall serve as the MCO’s primary liaison for meeting the needs of an enrollee who is:
   (a) A child in foster care; or
   (b) A child receiving state-funded adoption assistance;
(10) A guardianship liaison who shall serve as the MCO’s primary liaison for meeting the needs of an enrollee who is a ward of the Commonwealth;
(11) A management information systems director who shall oversee, manage, and maintain the MCO’s management information system;
(12) A program integrity coordinator who shall coordinate, manage, and oversee the MCO’s program integrity functions;
(13) A pharmacy director who shall coordinate, manage, and oversee the MCO’s pharmacy program;
(14) A compliance director who shall be responsible for the MCO’s:
   (a) Financial and programmatic accountability, transparency, and integrity; and
   (b) Compliance with:
      1. All applicable federal and state laws;
      2. Any administrative regulation promulgated by the department relating to the MCO; and
      3. The requirements established in the contract between the MCO and the department;
(15) A member services director who shall:
   (a) Coordinate communication with MCO enrollees; and
   (b) Respond in a timely manner to an enrollee seeking a resolution of a problem or inquiry;
(16) A provider services director who shall:
   (a) Coordinate communication with MCO providers and subcontractors; and
   (b) Respond in a timely manner to a provider seeking a resolution of a problem or inquiry; and
(17) A claims processing director who shall ensure the timely and accurate processing of claims.

Section 60. MCO Reporting Requirements. An MCO shall:
(1) Submit to the department a report as required by MCO Reporting Requirements;
(2) Verify the accuracy of data and information on a report submitted to the department;
(3) Analyze a required report to identify an early pattern of change, a trend, or an outlier before submitting the report to the department; and
(4) Submit the analysis required in subsection (3) of this section with a required report.

Section 61. Health Care Data Submission and Penalties. (1)(a) An MCO shall submit an original encounter record and denial encounter record, if any, to the department weekly.
(b) An original encounter record or a denial encounter record shall be considered late if not received by the department within four (4) calendar days from the weekly due date.
(c) Beginning on the fifth calendar day late, the department shall withhold $500 per day for each day late from an MCO’s total capitation payments for the month following non-submission of an original encounter record and denial encounter record.
(2)(a) If an MCO fails to submit health care data derived from processed claims or encounter data in a form or format established in the MCO Reporting Requirements, or if the required data is not received by the department within four (4) calendar days from the weekly due date, the department shall withhold an amount equal to five (5) percent of the MCO’s capitation payment for the month following non-submission.
(b) The department shall retain the amount referenced in paragraph (a) of this subsection until the data is received and accepted by the department, less $500 per day for each day late.
(3)(a) The department shall transmit to an MCO an encounter record with an error for correction by the MCO.
(b) An MCO shall have ten (10) days to submit a corrected encounter record to the department.
(c) If an MCO fails to submit a corrected encounter record within the time frame specified in paragraph (b) of this subsection, the department shall be able to assess and withhold for the month following the non-submission, an amount equal to one-tenth of a percent of the MCO’s total capitation payments per day until the corrected encounter record is received and accepted by the department.

Section 62. Program Integrity. An MCO shall comply with:
(1) 42 C.F.R. 438.608; and
(2) 42 U.S.C. 1396a(a)(68); and
(3) The requirements established in the MCO Program Integrity Requirements.

Section 63. Third Party Liability and Coordination of Benefits. (1) Medicaid shall be the payer of last resort for a service provided to an enrollee.
(2) An MCO shall:
   (a) Exhaust a payment by a third party prior to payment for a service provided to an enrollee;
   (b) Be responsible for determining a legal liability of a third party to pay for a service provided to an enrollee;
   (c) Actively seek and identify a third party liability resource to pay for a service provided to an enrollee in accordance with 42 C.F.R. 433.138; and
   (d) Assure that Medicaid shall be the payer of last resort for a service provided to an enrollee.
(3) In accordance with 907 KAR 1:011 and KRS 205.624, an enrollee shall:
   (a) Assign, in writing, the enrollee’s rights to an MCO for a medical support or payment from a third party for a medical service provided by the MCO; and
   (b) Cooperate with an MCO in identifying and providing information to assist the MCO in pursuing a third party that shall be liable to pay for a service provided by the MCO.
(4) If an MCO becomes aware of a third party liability resource after payment for a service provided to an enrollee, the MCO shall seek recovery from the third party resource.
(5) An MCO shall have a process for third party liability and coordination of benefits in accordance with Third Party Liability and Coordination of Benefits.

Section 64. Management Information System. (1) An MCO shall:
(a) Have a management information system that shall:
   1. Provide support to the MCO operations; and
   2. Except as provided in subsection (2) of this section, include:
      a. Member subsystem;
      b. Third party liability subsystem;
      c. Provider subsystem;
      d. Reference subsystem;
      e. Claim processing subsystem;
      f. Financial subsystem;
      g. Utilization and quality improvement subsystem; and
      h. Surveillance utilization review subsystem; and
   (b) Transmit data to the department in accordance with 42 C.F.R. 438.242 and the Management Information System Requirements.
(2) An MCO’s management information system shall not be required to have the subsystems listed in subsection (1)(a)(2) of this section if the MCO’s management information system:
   (a) Has the capacity to:
      1. Capture and provide the required data captured by the subsystems listed in subsection (1)(a)(2) of this section; and
      2. Provide the data in formats and files that shall be consistent with the subsystems listed in subsection (1)(a)(2) of this section; and
   (b) Meets the requirements established in paragraph (a) of this section.
subsection in a way which shall be mapped to the subsystem concept established in subsection (1)(b) of this section.

(3) If an MCO subcontract for services, the MCO shall provide guidelines for its subcontractor to the department for approval.

Section 65. Kentucky Health Information Exchange (KHIE). (1) An MCO shall:
(a) Submit to the KHIE:
1. An adjudicated claim within twenty-four (24) hours of the final claim adjudication; and
2. Clinical data as soon as it is available;
(b) Make an attempt to have a PDP in the MCO’s network connect to KHIE within:
1. One (1) year of enrollment in the MCO’s network; or
2. A timeframe approved by the department if greater than one (1) year; and
(c) Encourage a provider in its network to establish connectivity with the KHIE.
(2) The department shall:
(a) Administer an electronic health record incentive payment program; and
(b) Inform an MCO of a provider that has received an electronic health record incentive payment.

Section 66. MCO Qualifications and Maintenance of Records. (1) An MCO shall:
(a) Be licensed by the Department of Insurance as a health maintenance organization or an insurer;
(b) Have a governing body;
(c) Have protection against insolvency in accordance with:
1. 806 KAR 3:190;
2. 42 C.F.R. 438.116; and
(d) Maintain all books, records, and information related to MCO providers, recipients, or recipient services, and financial transactions for:
1. A minimum of five (5) years in accordance with 907 KAR 1:672; and
2. Any additional time period as required by federal or state law;
(e) Submit a request for disclosure of information subject to open records laws, KRS 61.870 to 61.884, received from the public to the department within twenty-four (24) hours.
(2) Information shall not be disclosed by an MCO pursuant to a request if it received pursuant to subsection (1)(e) of this section without prior written authorization from the department.
(3) The books, records, and information referenced in subsection (1)(d) of this section shall be available upon request of a reviewer or auditor during routine business hours at the MCO’s place of operations.
(4) MCO staff shall be available upon request of a reviewer or auditor during routine business hours at the MCO’s place of operations.

Section 67. Prohibited Affiliations. The policies or requirements for
(1) Imposed on a managed care entity in 42 U.S.C. 1396u-2(d)(1) shall apply to an MCO; and
(2) Established in 42 C.F.R. 438.610 shall apply to an MCO.

Section 68. Termination of MCO Participation in the Medicaid Program. If necessary, a contract with an MCO shall be terminated and the termination shall be in accordance with KRS Chapter 45A.

Section 69. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) “MCO Reporting Requirements”, July 2011 edition;
(b) “MCO Program Integrity Requirements”, July 2011 edition;
(c) “Early and Periodic Screening, Diagnosis and Treatment Program”, Periodically Schedule, July 2011 edition;
(d) “Third Party Liability and Coordination of Benefits”, July 2011 edition;
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m., or from its Web site at http://www.chfs.ky.gov/dms/incorporated.htm.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email jill.brown@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT
Contact Person: Stuart Owen
(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation currently establishes Kentucky Medicaid program managed care policies [excluding MCO policies for region three (3) of Kentucky]. Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than this lone administrative regulation. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. This administrative regulation; thus, will contain the definitions for Medicaid managed care administrative regulations. The other administrative regulations are new administrative regulations (907 KAR 17:010, 907 KAR 17:015, 907 KAR 17:020, 907 KAR 17:025 and 907 KAR 17:030) which will address subjects previously addressed in this administrative regulation and are all being promulgated concurrently along with this amended administrative regulation.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for Chapter 17 of title 907 which is the chapter that contains Kentucky Medicaid program managed care regulations. The definitions are not being amended from what is currently stated in this administrative regulation. DMS is establishing MCO requirements and policies in multiple administrative regulations rather than in this lone administrative regulation. DMS is doing this in response to urging from the Administrative Regulation Review Subcommittee and staff when this administrative regulation was reviewed by the committee earlier this year.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the definitions for Chapter 17 of title 907 which is the chapter that contains Kentucky Medicaid program managed care regulations.

(2) If this is an amendment to an existing administrative regulation provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This administrative regulation currently establishes Kentucky Medicaid program managed care policies but is being amended to establish the definitions for Chapter 17 of title 907 – which is the chapter that contains Kentucky Medicaid program...
managed care regulations. The Department for Medicaid Services (DMS) is dividing the current regulation into four (4) regulations.

(b) The necessity of the amendment to this administrative regulation: DMS is dividing the administrative regulation into four (4) regulatory rules in response to a request by the Administrative Regulation Review Subcommittee and staff when the regulation previously was reviewed by the Subcommittee.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by establishing the definitions for Chapter 17 of title 907 – which is the chapter that contains Kentucky Medicaid program managed care regulations.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by establishing the definitions for Chapter 17 of title 907 – which is the chapter that contains Kentucky Medicaid program managed care regulations.

(3) List the type and number of individuals, businesses, organizations, or state or local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No cost is imposed.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY) 2013 are $3,198,870,633.

(b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation establishes definitions to be used for regulations contains in Chapter 17 of title 907 of the Kentucky Administrative Regulations.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438.

2. State compliance standards. KRS 205.520(3) states, “Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary’s power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care but does not impose additional or different responsibilities or requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A managed care method of administering the program is being implemented but stricter requirements are not imposed. A managed care program is not federally mandated for Medicaid programs.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health department, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,198,870,633.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,303,448,347.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY

907 KAR 17:010E

This is a new emergency administrative regulation which is being promulgated concurrently with five (5) other administrative regulations which will establish the Kentucky Medicaid Program managed care organization requirements and policies. Currently, there is one administrative regulation (907 KAR 17:005) which establishes Kentucky Medicaid program managed care organization requirements and policies for every region except region three.

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(3). Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or nearby. Jefferson County and its requirements and policies are established in 907 KAR 1:705. One (1) managed care organization has been responsible for managed care in region three (3) since the mid-1990s; however, managed care in that region did not encompass behavioral health services, and having one (1) entity does not satisfy the Centers for Medicare and Medicaid Services (CMS) requirement of providing individuals choice of managed care organizations. Consequently, DMS has contracted with four (4) entities — including the entity that has been performing managed care organization functions since the mid-1990s — to be responsible for managed care in region three (3), and the scope of managed care in region three (3) will now include behavioral health services. As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 1:705) and establishing uniform managed care organization requirements and policies for all Medicaid managed care organizations in Kentucky. The six (6) administrative regulations which will accomplish this include this administrative regulation, 907 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:015 (managed care organization requirements and policies related to providers); 907 KAR 17:020 (managed care organization service and service coverage requirements and policies); 907 KAR 17:025 (managed care organization utilization management and quality requirements and policies); and 907 KAR 17:030 (managed care organization operational and related requirements and policies.) DMS is establishing managed care organization requirements across multiple administrative regulations in response to urging from the Administrative Regulation Review Subcommittee (ARRS) and ARRS staff when this administrative regulation was reviewed by the committee earlier this year. Providing a choice of managed care organizations to individuals is necessary to comply with a federal mandate, and expanding the scope of managed care in region three (3) to include behavioral health services is also necessary to establish the same managed care benefit package for all Medicaid recipients enrolled in managed care in Kentucky. This action must be implemented on an emergency basis to comply with a federal mandate and to prevent a loss of federal funds as CMS has approved DMS’s revised managed care model - four (4) entities and the scope of services includes behavioral health services — for region three (3). This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is different from this emergency administrative regulation in that it does not contain the January 1, 2013 effective date for the policy regarding retroactively eligible individuals who receive Supplemental Security Income benefits. The date is not in the ordinary administrative regulation as it will not be adopted prior to January 1, 2013.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office
(New Emergency Administrative Regulation)

907 KAR 17:010E. Managed care organization requirements and policies relating to enrollees.

RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R. 438

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396n(b), 42 C.F.R. Part 438, 2012 Ky. Acts ch. 144, Part 8, 1990 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:015 (managed care organization requirements and policies related to providers); 907 KAR 17:020 (managed care organization service and service coverage requirements and policies); 907 KAR 17:025 (managed care organization utilization management and quality requirements and policies); and 907 KAR 17:030 (managed care organization operational and related requirements and policies.)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the managed care organization requirements and policies relating to individuals enrolled with a Medicaid managed care organization.

Section 1. Enrollment of Medicaid or KCHIP Recipients into Managed Care. (1) Except as provided in subsection (3) of this section, enrollment into a managed care organization shall be mandatory for a Medicaid or KCHIP recipient.

(2) The provisions in this administrative regulation shall be applicable to a recipient who is:

(a) Medicaid recipient; or
(b) KCHIP recipient.

(3) The following recipients shall not be required to enroll, and shall not enroll, into a managed care organization:

(a) A recipient who resides in:
1. A nursing facility for more than thirty (30) days; or
2. An intermediate care facility for individuals with mental retardation or a developmental disability; or
(b) A recipient who is:
1. Determined to be eligible for Medicaid benefits due to a nursing facility admission; 2. Receiving:
   a. Services through the breast and cervical cancer program pursuant to 907 KAR 18:050 and the
      administration of the breast and cervical screening program administered by the
      Department for Medicaid Services (CMS) requirement of providing individuals
      meeting the breast and cervical cancer program eligibility criteria for services
      established in 907 KAR 1:640; b. Medicaid benefits in accordance with the spend-down policies established in 907 KAR 1:640;
   c. Services through a 1915(c) home and community based services waiver program;
   d. Hospice services in a nursing facility or intermediate care facility for individuals with mental retardation or a developmental disability; or
   e. Medicaid benefits as a Medicaid Works individual;
   f. A Qualified Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   g. A Medicare qualified individual group 1 (QI-1) individual;
   h. A qualified disabled and working individual;
   i. A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   j. A Medicare qualified individual group 1 (QI-1) individual.
   k. A Medicare qualified individual group 1 (QI-1) individual;
   l. A qualified disabled and working individual;
   m. A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   n. A Medicare qualified individual group 1 (QI-1) individual;
   o. A qualified disabled and working individual;
   p. A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   q. A Medicare qualified individual group 1 (QI-1) individual;
   r. A qualified disabled and working individual;
   s. A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   t. A Medicare qualified individual group 1 (QI-1) individual;
   u. A qualified disabled and working individual;
   v. A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   w. A Medicare qualified individual group 1 (QI-1) individual;
   x. A qualified disabled and working individual;
   y. A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   z. A Medicare qualified individual group 1 (QI-1) individual;
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   c A qualified disabled and working individual;
   d A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   e A Medicare qualified individual group 1 (QI-1) individual;
   f A qualified disabled and working individual;
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   r A qualified disabled and working individual;
   s A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   t A Medicare qualified individual group 1 (QI-1) individual;
   u A qualified disabled and working individual;
   v A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   w A Medicare qualified individual group 1 (QI-1) individual;
   x A qualified disabled and working individual;
   y A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   z A Medicare qualified individual group 1 (QI-1) individual;
   0 A qualified disabled and working individual;
   1 A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   2 A Medicare qualified individual group 1 (QI-1) individual;
   3 A qualified disabled and working individual;
   4 A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   5 A Medicare qualified individual group 1 (QI-1) individual;
   6 A qualified disabled and working individual;
   7 A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;
   8 A Medicare qualified individual group 1 (QI-1) individual;
   9 A qualified disabled and working individual;
   10 A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;

(b) If a recipient does not choose an MCO during the eligibility application process, the department shall select an MCO for the recipient.

(4) An assignment shall focus on a need of a child or an individual with a special health care need.

(b) An assignment shall focus on a need of a child or an individual with a special health care need.

(5) A recipient who is entitled to enrollment into a managed care organization shall be enrolled with an MCO that provides services to an enrollee whose primary residence is within the MCO’s service area.

(b) A child in foster care shall be enrolled with an MCO in the county where the child’s DCBS case is located.

(6) A recipient who is entitled to enrollment into a managed care organization shall be enrolled with an MCO that provides services to an enrollee whose primary residence is within the MCO’s service area.

(b) A recipient who is entitled to enrollment into a managed care organization shall be enrolled with an MCO that provides services to an enrollee whose primary residence is within the MCO’s service area.

(7) Each member of a household shall be assigned to the same MCO.

(b) Each member of a household shall be assigned to the same MCO.

(8) The effective date of enrollment for a recipient described in subsection (6) of this section shall be:

(a) The date of Medicaid eligibility; and
(b) No earlier than January 1, 2013 for region three.

(9) A recipient shall be given a choice of MCOs.

(10) A recipient enrolled with an MCO who loses Medicaid eligibility for less than two (2) months shall be automatically reen-
nrolled with the same MCO upon redetermination of Medicaid eligibility unless the recipient moves outside of the MCO’s regional coverage.

(1) A newborn who has been deemed eligible for Medicaid shall be automatically enrolled with the newborn’s mother’s MCO as an individual enrollee for up to sixty (60) days.

(12)(a) An enrollee may change an MCO for any reason, regardless of whether the MCO was selected by the enrollee or assigned by the department:

1. Within ninety (90) days of the effective date of enrollment;
2. Annually during an open enrollment period;
3. Upon automatic enrollment under subsection (10) of this section, if a temporary loss of Medicaid eligibility caused the recipient to miss the annual opportunity in subparagraph 2. of this paragraph;

(b) An MCO shall accept an enrollee who changes MCOs under this section.

(13) Only the department shall have the authority to enroll a Medicaid recipient with an MCO in accordance with this section.

(14) Upon enrollment with an MCO, an enrollee shall receive two (2) identification cards.

(a) A card shall be issued from the department that shall verify Medicaid eligibility.

(b) A card shall be issued by the MCO that shall verify enrollment with the MCO.

(15)(a) Within five (5) business days after receipt of notification of a new enrollee, an MCO shall send, by a method that shall not take more than three (3) days to reach the enrollee, a confirmation letter to an enrollee.

(b) The confirmation letter shall include at least the following information:

1. The effective date of enrollment;
2. The name, location, and contact information of the PCP;
3. How to obtain a referral;
4. Care coordination;
5. The benefits of preventive health care;
6. The enrollee identification card;
7. A member handbook; and
8. A list of covered services.

(16) Enrollment with an MCO shall be without restriction.

(17) An MCO shall:

(a) Have continuous open enrollment for new enrollees; and
(b) Accept enrollees regardless of overall enrollment.

(18)(a) Except as provided in paragraph (b) through (e) of this subsection, a recipient eligible to enroll with an MCO shall be enrolled beginning with the first day of the month that the enrollee applied for Medicaid.

(b) A newborn shall be enrolled beginning with the newborn’s date of birth.

(c) An unemployed parent shall be enrolled beginning with the date the unemployed parent met the definition of unemployment in accordance with 45 C.F.R. 233.100.

(d)1. If an enrollee is retroactively determined eligible for Medicaid, the retroactive eligibility, except for an individual who has been determined to be eligible for SSI benefits, shall be for a period up to three (3) months prior to the month that the enrollee applied for Medicaid.

2. Except as established in paragraph (f) of this subsection, an MCO shall be responsible for reimbursing for covered services provided to a retroactively determined eligible individual referenced in subparagraph 1. of this paragraph during the individual’s retroactive eligibility period.

(e) If an enrollee is retroactively determined eligible for Medicaid as a result of being determined retroactively eligible for SSI benefits:

1. The individual’s enrollment date with an MCO shall be the first of the month following the month in which the department notified the individual’s retroactive eligibility for SSI benefits; and
2. The department shall be responsible for reimbursing for any services provided during the retroactive eligibility period for an individual determined to be retroactively eligible for SSI benefits.

(f) In addition to the reimbursement obligation described in paragraph (e)2. of this subsection, the department shall be responsible for reimbursing for services provided to an individual:

1. Determined to be retroactively eligible for any portion of the retroactive eligibility period which occurred prior to November 1, 2011 for regions one (1), two (2), four (4), five (5), six (6), seven (7) and eight (8) if the individual has a retroactive eligibility period prior to November 1, 2011; or
2. Determined to be retroactively eligible for any portion of the retroactive eligibility period which occurred prior to January 1, 2013 for region three (3) if the individual has a retroactive eligibility period prior to January 1, 2013.

(g) The policy stated in paragraph (e)2. and (f)2. of this subsection shall be:

1. Effective January 1, 2013 contingent upon approval by the Centers for Medicare and Medicaid Services (CMS); and
2. Implemented upon approval by CMS.

(19) For an enrollee whose eligibility resulted from a successful appeal of a denial of eligibility, the enrollment period shall begin:

(a) On the first day of the month of the original application for eligibility; or
2. On the first day of the month of retroactive eligibility as referenced in subsection (18)(d) or (e) of this section, if applicable; and
(b) No earlier than:

1. November 1, 2011 for regions one (1), two (2), four (4), five (5), six (6), seven (7), and eight (8); or
2. January 1, 2013 for region three (3).

(20) A provider shall be responsible for verifying an individual’s eligibility for Medicaid and enrollment in a managed care organization when providing a service.

Section 2. Disenrollment. (1) The policies established in 42 C.F.R. 438.56 shall apply to an MCO.

(2) Only the department shall have the authority to disenroll a recipient from an MCO.

(3) A disenrollment of a recipient from an MCO shall:

(a) Become effective on the first day of the month following disenrollment; and

(b) Occur:

1. If the enrollee: a. No longer resides in an area served by the MCO; b. Becomes incarcerated or deceased; or c. Is exempt from managed care enrollment in accordance with Section 1(3) of this administrative regulation; or
2. At least ninety (90) days prior to the first day of the second month following the month of disenrollment.

(4) An MCO may recommend to the department that an enrollee be disenrolled if the enrollee:

(a) Is found guilty of fraud in a court of law or administratively determined to have committed fraud related to the Medicaid Program;

(b) Is abusive or threatening but not for uncooperative or disruptive behavior resulting from his or her special needs (except if his or her continued enrollment in the Medicaid program seriously impairs the entity’s ability to furnish services to other enrollees or the enrollee himself or herself) pursuant to 42 C.F.R. 438.56(b)(2);

(c) Becomes deceased; or

(d) No longer resides in an area served by the MCO.

(5) An enrollee shall not be disenrolled by the department, nor shall the managed care organization recommend disenrollment of an enrollee, due to an adverse change in the enrollee’s health.

(6)(a) An approved disenrollment shall be effective no later than the first day of the second month following the month the enrollee or the MCO files a request in accordance with 42 C.F.R. 438.56(e)(1).

(b) If the department fails to make a determination within the timeframe specified in paragraph (a) of this subsection, the disenrollment shall be considered approved in accordance with 42 C.F.R. 438.56(e)(2).

(7) If an enrollee is disenrolled from an MCO, the:

(a) Enrollee shall be enrolled with a new MCO if the enrollee is: 1. Eligible for Medicaid; and
2. Not excluded from managed care participation; and
(b) MCO shall:
1. Assist in the selection of a new primary care provider, if requested;
Section 3. Enrollee Rights and Responsibilities. (1) An MCO shall have written policies and procedures:

(a) To protect the rights of an enrollee that includes the:

1. Protection against liability for payment in accordance with 42 U.S.C. 1396u-2(b)(6);
2. Rights specified in 42 C.F.R. 438.100;
3. Right to prepare an advance medical directive pursuant to KRS 311.621 through KRS 311.643;
4. Right to choose and change a primary care provider;
5. Right to file a grievance or an appeal;
6. Right to receive assistance in filing a grievance or an appeal;
7. Right to a state fair hearing;
8. Right to a timely referral and access to medically indicated specialty care; and
9. Right to access the enrollee’s medical records in accordance with federal and state law; and
(b) Regarding the responsibilities of enrollees that include the responsibility to:

1. Become informed about:
   a. Enrollee rights specified in paragraph (a) of this subsection; and
   b. Service and treatment options;
2. Abide by the MCO’s and department’s policies and procedures;
3. Actively participate in personal health and care decisions;
4. Report suspected fraud or abuse; and
5. Keep appointments or call to cancel if unavailable to keep an appointment.

(2) The information specified in subsection (1) of this section shall meet the information requirements established in 42 C.F.R. 438.10.

Section 4. MCO Internal Appeal Process. (1) An MCO shall have written policies and procedures describing how an enrollee shall submit a request for:

(a) A grievance with the MCO;
(b) An appeal with the MCO; or
(c) A state fair hearing in accordance with KRS Chapter 13B.

(2) An enrollee shall have thirty (30) calendar days from the date of an event causing dissatisfaction to file a grievance orally or in writing with the MCO.

(a) Within five (5) working days of receipt of a grievance, an MCO shall provide the enrollee with written notice that the grievance has been received and the expected date of its resolution.
(b) An investigation and final resolution of a grievance shall:
1. Be completed within thirty (30) calendar days of the date the grievance is received by the MCO; and
2. Include a resolution letter to the enrollee that shall include:
   a. All information considered in investigating the grievance;
   b. Findings and conclusions based on the investigation; and
   c. The disposition of the grievance.

(3) An MCO shall have an internal appeal process in place that allows an enrollee to challenge a denial of coverage of, or payment for, a service in accordance with 42 C.F.R. 438.400 through 438.424 and 42 U.S.C. 1396u-2(b)(4).

(4)(a) A provider shall not be an authorized representative of an enrollee without the enrollee’s written consent for the specific action that is being appealed or that is the subject of a state fair hearing.
(b) The written consent referenced in paragraph (a) of this subsection shall be signed and dated by the enrollee no earlier than the date of the MCO’s action.

(5) A legal guardian of an enrollee who is a minor or an incapacitated adult or an authorized representative of an enrollee in accordance with subsection (4) of this section shall have the right to file an appeal on behalf of the enrollee.

(6) An enrollee shall have thirty (30) calendar days from the date of receiving a notice of adverse action from an MCO to file an appeal either orally or in writing with the MCO.

(7) An MCO shall resolve an appeal within thirty (30) calendar days from the date the initial oral or written appeal is received by the MCO.

(8) An MCO shall have a process in place that ensures that an oral or written inquiry from an enrollee seeking to appeal an adverse action is treated as an appeal to establish the earliest possible filing date for the appeal.

(9) An oral appeal shall be followed by a written appeal that is signed by the enrollee within ten (10) calendar days.

(10)(a) Within five (5) working days of receipt of an appeal, an MCO shall provide the enrollee with written notice that the appeal has been received and the expected date of its resolution.
(b) An MCO shall confirm in writing receipt of an oral appeal unless an expedited resolution has been requested.

11 An MCO shall extend the thirty (30) day timeframe for resolution of an appeal established in subsection (7) of this section by fourteen (14) calendar days if:

(a) The enrollee requests the extension; or
(b) 1. The MCO demonstrates to the department that there is need for additional information; and
2. The extension is in the enrollee’s interest.

(12) For an extension requested by an MCO, the MCO shall give the enrollee written notice of the extension and the reason for the extension within two (2) working days of the decision to extend.

(13)(a) For an appeal, an MCO shall provide written notice of its decision within thirty (30) calendar days to an enrollee or a provider, if the provider filed the appeal.
(b) The provider shall:
1. Give a copy of the notice to the enrollee; or
2. Inform the enrollee of the provisions of the notice.

(14) An MCO shall:

(a) Continue to provide benefits to an enrollee, if the enrollee requested a continuation of benefits, until one (1) of the following occurs:
1. The enrollee withdraws the appeal;
2. Fourteen (14) days have passed since the date of the resolution letter, if the resolution of the appeal was against the enrollee and the enrollee has not requested a state fair hearing or taken any further action; or
3. A state fair hearing decision adverse to the enrollee has been issued;

(b) Have an expedited review process for appeals if the MCO determines that allowing the time for a standard resolution could seriously jeopardize an enrollee’s life or health or ability to attain, maintain, or regain maximum function;
(c) Resolve an expedited appeal within three (3) working days of receipt of the request; and
(d) Extend the timeframe for an expedited appeal established in paragraph (c) of this subsection by up to fourteen (14) calendar days if:
1. The enrollee requests the extension; or
2. a. The MCO demonstrates to the department that there is need for additional information; and
b. The extension is in the enrollee’s interest.

(15) For an extension requested by an MCO, the MCO shall give the enrollee written notice of the reason for the extension.

(16) If an MCO denies a request for an expedited resolution of an appeal, it shall:

(a) Transfer the appeal to the thirty (30) day timeframe for a standard resolution, in which the thirty (30) day period shall begin on the date the MCO received the original request for appeal;
(b) Give prompt oral notice of the denial; and
(c) Follow up with a written notice within two (2) calendar days of the denial.

(17) An MCO shall document in writing an oral request for an expedited resolution and shall maintain the documentation in the enrollee case file.

(18) An MCO shall:

(a) Provide information specified in 42 C.F.R. 438.10(g)(1) about the grievance system to a service provider and a subcon-
tractor at the time they enter into a contract;
(b) Maintain a grievance or an appeal file in a secure and designated area;
(c) Make a grievance or an appeal file accessible to the department or its designee upon request;
(d) Retain a grievance or an appeal file for ten (10) years following a final decision by the MCO, the department, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later;
(e) Have procedures for assuring that a grievance or an appeal file contains:
   1. Information to identify the grievance or appeal;
   2. The date a grievance or appeal was received;
   3. The nature of the grievance or appeal;
   4. A notice to the enrollee of receipt of the grievance or appeal;
   5. Correspondence between the MCO and the enrollee;
   6. The date the grievance or appeal is resolved;
   7. The decision made by the MCO of the grievance or appeal;
   8. The notice of a final decision to the enrollee; and
   9. Information pertaining to the grievance or appeal; and
(f) Make available to an enrollee documentation regarding a grievance or an appeal.

(19) An MCO shall designate an individual to:
(a) Execute the policies and procedures for resolution of a grievance or appeal;
(b) Review policies or trends in grievances or appeals; and
(c) Initiate a corrective action, if needed.

(20) If an MCO takes adverse action at the conclusion of an internal appeal process, the MCO shall issue an adverse action letter to the enrollee that complies with KRS 13B.050(3)(d) and (e).

(21)(a) The requirements and policies stated in this section of this administrative regulation regarding an MCO appeal shall apply to an MCO.

(b) If a requirement or policy regarding an appeal or an MCO appeal stated in another Kentucky administrative regulation within Title 907 of the Kentucky Administrative Regulations contradicts a requirement or policy regarding an MCO appeal that is stated in this section of this administrative regulation, the requirement or policy stated in the other administrative regulation shall not apply to an MCO.

Section 5. Department's State Fair Hearing for an Enrollee. (1) An enrollee shall have a right to a state fair hearing administered by the department in accordance with KRS Chapter 138 only after exhausting an MCO's internal appeal process.

(2) The department shall provide an enrollee with a hearing process that shall adhere to 907 KAR 1:563; 42 C.F.R. 438, Subparts A, C, and D; 42 C.F.R. 431, Subpart E. (3)(a) An enrollee or authorized representative may request a state fair hearing by filing a written request with the department.

(b) If an enrollee or authorized representative requests a hearing, the request shall:
1. Be in writing and specify the reason for the request;
2. Indicate the date of service or the type of service denied; and
3. Be postmarked or filed within forty-five (45) days from the date of the MCO adverse action letter issued at the conclusion of the MCO internal appeal process.

(4) A document supporting an MCO's adverse action shall be:
(a) Received by the department no later than five (5) days from the date a notice is sent to the MCO from the department that a request for a state fair hearing has been filed by an enrollee; and
(b) Made available to an enrollee upon request by either the enrollee or the enrollee's legal counsel.

(5) An automatic ruling shall be made by the department in favor of an enrollee if an MCO fails to:
(a) Comply with the requirements of:
1. Section 4 of this administrative regulation; and
2. Subsection (4) of this section; or
(b) Participate in and present evidence at the state fair hearing.

Section 6. Member Services. (1) An MCO shall have a member services function that includes a member call center and a behavioral health call center that shall:

(a) Be staffed Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Time; and
(b) Meet the call center standards, which shall:
1. Be approved by the American Accreditation Health Care Commission or Utilization Review Accreditation Committee (URAC); and
2. Include provisions addressing the call center abandonment rate, blockage rate, and average speed of answer.

(2)(a) An MCO shall provide access to medical advice to an enrollee through a toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week.

(b) The call-in system shall be staffed by medical professionals to include:
1. Physicians;
2. Physician assistants;
3. Licensed practical nurses; or
4. Registered nurses.

(3) An MCO shall:
(a) Provide foreign language interpreter services, free of charge, for an enrollee;
(b) Respond to the special communication needs of the disabled, blind, deaf, or aged;
(c) Facilitate direct access to a specialty physician for an enrollee:
   1. With a chronic or complex health condition;
   2. Who is aged, blind, deaf, or disabled; or
   3. Identified as having a special healthcare need and requiring a course of treatment or regular healthcare monitoring;
(d) Arrange for and assist with scheduling an EPSDT service in conformance with federal law governing EPSDT;
(e) Provide an enrollee with information or refer the enrollee to a support service;
(f) Facilitate direct access to a covered service in accordance with 907 KAR 17:020;
(g) Facilitate access to a:
   1. Behavioral health service;
   2. Pharmaceutical service; or
   3. Service provided by a public health department, community mental health center, rural health clinic, federally qualified health center, the Commission for Children with Special Health Care Needs, or a charitable care provider;
(h) Assist an enrollee in:
   1. Scheduling an appointment with a provider;
   2. Obtaining transportation for an emergency or non-emergency service;
   3. Completing a health risk assessment; or
   4. Accessing an MCO health education program;
   5. Process, record, and track an enrollee grievance and appeal; or
   (j) Refer an enrollee to case management or disease management.

Section 7. Enrollee Selection of Primary Care Provider. (1) Except for an enrollee described in subsection (2) of this section, an MCO shall have a process for enrollee selection and assignment of a primary care provider.

(2) The following shall not be required to have, but may request, a primary care provider:
(a) A dual eligible;
(b) A child in foster care;
(c) A child under the age of eighteen (18) years who is disabled; or
(d) A pregnant woman who is presumptively eligible pursuant to 907 KAR 1:810.

(3)(a) For an enrollee who is not receiving supplemental security income benefits:
1. An MCO shall notify the enrollee within ten (10) days of notification of enrollment by the department of the procedure for choosing a primary care provider; and
2. If the enrollee does not choose a primary care provider, an MCO shall assign to the enrollee a primary care provider who:
   a. Has historically provided services to the enrollee; and
   b. Meets the requirements of subsection (6) of this section.

(b) If no primary care provider meets the requirements of para-
graph (a)2 of this subsection, an MCO shall assign the enrollee to a primary care provider who is within:
1. Thirty (30) miles or thirty (30) minutes from the enrollee’s residence if the enrollee is in an urban area; or
2. Forty-five (45) miles or forty-five (45) minutes from the enrollee’s residence if the enrollee is in a rural area.

(4)(a) For an enrollee who is receiving supplemental security income benefits and is not a dual eligible, an MCO shall notify the enrollee of the procedure for choosing a primary care provider.

(b) If an enrollee has not chosen a primary care provider within thirty (30) days, an MCO shall send a second notice to the enrollee.

(c) If an enrollee has not chosen a primary care provider within thirty (30) days of the second notice, the MCO shall send a third notice to the enrollee.

(d) If an enrollee has not chosen a primary care provider after the third notice, the MCO shall assign a primary care provider.

(e) Except for an enrollee who was previously enrolled with the MC

(2) primary care providers within an MCO’s provider network.

(b) At least one (1) of the two (2) primary care providers referenced in paragraph (a) of this subsection shall be a physician.

(6) A primary care provider shall:

(a) Be a licensed or certified health care practitioner who functions within the provider’s scope of licensure or certification, including:
1. A physician;
2. An advanced practice registered nurse;
3. A physician assistant; or
4. A clinic, including a primary care center, federally qualified health center, or rural health clinic;

(b) Have admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges;

(c) Agree to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to enrollees; and

(d) For an enrollee who has a gynecological or obstetrical health care need, a disability, or chronic illness, be a specialist who agrees to provide or arrange for primary and preventive care.

2. Upon enrollment in an MCO, an enrollee shall have the right to change primary care providers:

(a) Within the first ninety (90) days of assignment;

(b) Once a year regardless of reason;

(c) At any time for a reason approved by the MCO;

(d) If during a temporary loss of eligibility, an enrollee loses the opportunity provided by paragraph (b) of this subsection;

(e) If Medicare or Medicaid imposes a sanction on the PCP;

(f) If the PCP is no longer in the MCO’s provider network; or

(g) At any time with cause which shall include the enrollee:

1. Receiving poor quality of care;

2. Lacking access to providers qualified to treat the enrollee’s medical condition; or

3. Being denied access to needed medical services.

A PCP shall not be able to request the reassignment of an enrollee to a different PCP for the following reasons:

(a) A change in the enrollee’s health status or treatment needs;

(b) An enrollee’s utilization of health services;

(c) An enrollee’s diminished mental capacity; or

(d) Disruptive behavior of an enrollee due to the enrollee’s special health care needs unless the behavior impairs the PCP’s ability to provide services to the enrollee or others.

(9) A PCP change request shall not be based on race, color, national origin, disability, age, or gender.

(10) An MCO shall have the authority to approve or deny a primary care provider change.

(11) An enrollee shall be able to obtain the following services outside of an MCO’s provider network:

(a) A family planning service in accordance with 42 C.F.R. 438.114;
(b) An emergency service in accordance with 42 C.F.R. 438.114;
(c) A poststabilization service in accordance with 42 C.F.R. 422.113;c; or

(d) An out-of-network service that an MCO is unable to provide within its network to meet the medical need of the enrollee in accordance with 42 C.F.R. 438.206(b)(4) subject to any prior authorization requirements of the MCO.

(12) An MCO shall:

(a) Notify an enrollee within:

1. Thirty (30) days of the effective date of a voluntary termination of the enrollee’s primary care provider; or

2. Fifteen (15) days of an involuntary termination of the enrollee’s primary care provider; and

(b) Assist the enrollee in selecting a new primary care provider.

Section 8. Member Handbook. (1) An MCO shall:

(a) Send a member handbook to an enrollee, by a method that shall not take more than three (3) days to reach the enrollee, within five (5) business days of enrollment;

(b) Review the member handbook at least annually;

(c) Communicate a change to the member handbook to an enrollee in writing, and

(d) Add a revision date to the member handbook after revising the member handbook.

(2) A member handbook shall:

(a) Be available:

1. In hardcopy in English, Spanish, and any other language spoken by at least five (5) percent of the potential enrollee or enrollee population; and

2. On the MCO’s Web site;

(b) Be written at no higher than a sixth grade reading comprehension level; and

(c) Include at a minimum the following information:

1. The MCO’s network of primary care providers, including the names, telephone numbers, and service site addresses of available primary care providers, and, if desired by the MCO, the names and contact information for other providers included in the MCO’s network;

2. The procedures for:

a. Selecting a PCP and scheduling an initial health appointment;

b. Obtaining:

(i) Emergency or non-emergency care after hours;

(ii) Transportation for emergency or non-emergency care;

(iii) An EPSDT service;

(iv) A covered service from an out-of-network provider; or

(v) A long term care service;

(c) Notifying DCBS of a change in family size or address, a birth, or a death of an enrollee;

(d) Selecting or requesting to change a PCP;

(e) A reason a request for a change may be denied by the MCO;

(i) A reason a provider may request to transfer an enrollee to a different PCP; and

f. Filing a grievance or appeal, including the title, address, and telephone number of the person responsible for processing and resolving a grievance or appeal;

3. The name of the MCO, address, and telephone number from which it conducts its business;

4. The MCO’s:

a. Business hours; and

b. Member service and toll-free medical call-in telephone numbers;

5. Covered services, an explanation of any service limitation or exclusion from coverage, and a notice stating that the MCO shall be liable only for those services authorized by the MCO, except for the services excluded in Section 7(11) of this administrative regulation;

6. Member rights and responsibilities;

7. For a life-threatening situation, instructions to use the emergency medical services available or to activate emergency medical services by dialing 911;

8. Information on:

a. The availability of maternity and family planning services, and for the prevention and treatment of sexually transmitted diseases;

b. Accessing the services referenced in clause a. of this subpa-
ragraph;  
c. Accessing care before a primary care provider is assigned or chosen;  
d. The Cabinet for Health and Family Services’ independent ombudsman program; and  
e. The availability of, and procedures for, obtaining:  
(i) A behavioral health or substance abuse service;  
(ii) A health education service; and  
(iii) Case coordination, case management, and disease management services;  
9. Direct access services that may be accessed without a referral; and  
10. An enrollee’s right to obtain a second opinion and information on obtaining a second opinion; and  
(d) Meet the information requirements established in Section 11 of this administrative regulation.  
(3) Changes to the member handbook shall be approved by the department prior to the publication of the handbook.  

Section 9. Member Education and Outreach. (1) An MCO shall:  
(a) Have an enrollee and community education and outreach program throughout the MCO’s service area;  
(b) Submit an annual outreach plan to the department for approval;  
(c) Assess the homeless population within its service area by implementing and maintaining an outreach plan for homeless individuals, including victims of domestic violence; and  
(d) Not differentiate between a service provided to an enrollee who is homeless and an enrollee who is not homeless.  
(2) An MCO’s outreach plan shall include:  
(a) Utilizing existing community resources including shelters and clinics; and  
(b) Face-to-face encounters.  

Section 10. Enrollee Non-Liability for Payment. (1) Except as specified in 907 KAR 17:030, an enrollee shall not be required to pay for a medically necessary covered service provided by the enrollee’s MCO.  
(2) An MCO shall not impose cost sharing on an enrollee greater than the limits established by the department in 907 KAR 1:604.  

Section 11. Provision of Information Requirements. (1) An MCO shall:  
(a) Comply with the requirements established in 42 U.S.C. 1396u-2(a)(5) and 42 C.F.R. 438.10; and  
(b) Provide translation services to an enrollee on site or via telephone.  
(2) Written material provided by an MCO to an enrollee or potential enrollee shall:  
(a) Be written at a sixth grade reading comprehension level;  
(b) Be published in at least a fourteen (14) point font;  
(c) Comply with the requirements established in 42 U.S.C. Chapter 126, the Americans with Disabilities Act;  
(d) Be updated as necessary to maintain accuracy;  
(e) Be available in Braille or in an audio format for an individual who is partially blind or blind; and  
(f) Be provided and printed in each language spoken by five (5) percent or more of the enrollees in each county.  
(3)(a) All written material intended for an enrollee, unless unique to an individual enrollee or exempted by the department, shall be submitted to the department for review and approval prior to publication or distribution to the enrollee.  
(b) Written material submitted to the department for review by an MCO shall be considered approved by the department if the department does not object or notify an MCO within:  
1. Thirty (30) days regarding a standard submission; or  
2. Five (5) days regarding an expedited submission.  
(c) Written material submitted to the department for review and approval shall be considered received for review beginning with the date that the commissioner or a deputy commissioner of the department acknowledges, to the MCO, receipt of the submission.  
2. The acknowledgement referenced in subparagraph 1 of this paragraph may be demonstrated by evidence of a return receipt if sent via U.S. Mail, a read receipt if sent via e-mail, or the signature of a Cabinet for Health and Family Services employee taking receipt of the submission in the case of hand-delivery, including overnight mail or courier delivery.  

Section 12. Confidentiality of Medical Information. (1) An MCO shall:  
(a) Maintain confidentiality of all enrollee eligibility information and medical records;  
(b) Prevent unauthorized disclosure of the information referenced in this subsection in accordance with KRS 194A.060, KRS 214.185, KRS 434.840 to 434.860, and 42 C.F.R. 431 Subpart F, 431.300 to 431.307;  
(c) Have written policies and procedures for maintaining the confidentiality of enrollee records;  
(d) Comply with 42 U.S.C. 1320d-2, the Health Insurance Portability and Accountability Act, and 45 C.F.R. Parts 160 and 164;  
(e) On behalf of its employees and agents:  
1. Sign a confidentiality agreement attesting that it will comply with the confidentiality requirements established in this section; and  
2. Submit the confidentiality agreement referenced in subparagraph 1 of this paragraph to the department;  
(f) Limit access to medical information to a person or agency which requires the information in order to perform a duty related to the department’s administration of the Medicaid program, including the department, the United States Department of Health and Human Services, the United States Attorney General, the CHFS OIG, the Kentucky Attorney General, or other agency required by the department; and  
(g) Submit a request for disclosure of information referenced in this subsection which has been received by the MCO to the department within twenty-four (24) hours.  
(2) Information referenced in subsection (1)(g) of this section shall not be disclosed by an MCO pursuant to the request without prior written authorization from the department.  

Section 13. Americans with Disabilities Act and Cabinet Ombudsman. (1) An MCO shall:  
(a) Require by contract with its network providers and subcontractors that a service location meets:  
1. The requirements established in 42 U.S.C. Chapter 126, the Americans with Disabilities Act; and  
2. All local requirements which apply to health facilities pertaining to adequate space, supplies, sanitation, and fire and safety procedures;  
(b) Fully cooperate with the Cabinet for Health and Family Services independent ombudsman; and  
(c) Provide immediate access to the Cabinet for Health and Family Services independent ombudsman, to an enrollee’s records if the enrollee has given consent.  
(2) An MCO’s member handbook shall contain information regarding the Cabinet for Health and Family Services independent ombudsman program.  

Section 14. Marketing. (1) An MCO shall:  
(a) Comply with the requirements established in 42 C.F.R. 438.104 regarding marketing activities;  
(b) Have a system of control over the content, form, and method of dissemination of its marketing and information materials;  
(c) Submit a marketing plan and marketing materials to the department for written approval prior to implementation or distribution;  
(d) If conducting mass media marketing, direct the marketing activities to enrollees in the entire service area pursuant to the marketing plan;  
(e) Not conduct face-to-face marketing;  
(f) Not use fraudulent, misleading, or misrepresentative information in its marketing materials;  
(g) Not offer material or financial gain to a:  
1. Potential enrollee as an inducement to select a particular provider or use a product; or  
2. Person for the purpose of soliciting, referring, or otherwise
facilitating the enrollment of an enrollee;

(h) Not conduct:
1. Direct telephone marketing to enrollees or potential enrollees who do not reside in the MCO service area; or
2. Direct or indirect door-to-door, telephone, or other cold-call marketing activity; and
(i) Not include in its marketing materials an assertion or statement that CMS, the federal government, the Commonwealth, or another entity endorses the MCO.

(2) An MCO’s marketing material shall meet the information requirements established in Section 11 of this administrative regulation.

Section 15. Legal Guardians. (1) A parent, custodial parent, person exercising custodial control or supervision, or an agency with a legal responsibility for a child by virtue of a voluntary commitment or of an emergency or temporary custody order shall be authorized to act on behalf of an enrollee who is under the age of eighteen (18) years, a potential enrollee, or a former enrollee for the purpose of:

(a) Selecting a primary care provider;
(b) Filing a grievance or appeal; or
(c) Taking an action on behalf of the child regarding an interaction with an MCO.

(2)(a) A legal guardian who has been appointed pursuant to KRS 387.500 to 387.800 shall be allowed to act on behalf of an enrollee who is a ward of the Commonwealth;
(b) A person authorized to make a health care decision pursuant to KRS 311.621 to 311.643 shall be allowed to act on behalf of an enrollee, potential enrollee, or former enrollee.

(c) An enrollee shall have the right to:
1. Represent the enrollee; or
2. Use legal counsel, a relative, a friend, or other spokesperson.

Section 16. Enrollee Surveys. (1) An MCO shall:
(a) Conduct an annual survey of enrollee satisfaction of the quality and accessibility to a service provided by an MCO;
(b) Satisfy a member satisfaction survey requirement by participating in the Agency for Health Research and Quality’s current Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) for Medicaid Adults and Children, which shall be administered by an NCQA-certified survey vendor;
(c) Provide a copy of the current CAHPS survey referenced in paragraph (b) of this subsection to the department;
(d) Annually assess the need for conducting other surveys to support quality and performance improvement initiatives;
(e) Submit to the department for approval the survey tool used to conduct the survey referenced in paragraph (a) of this subsection; and
(f) Provide to the department:
1. A copy of the results of the enrollee surveys referenced in paragraph (a) of this subsection;
2. A description of a methodology to be used to conduct surveys;
3. The number and percentage of enrollees surveyed;
4. Enrollee survey response rates;
5. Enrollee survey findings; and
6. Interventions conducted or planned by the MCO related to activities in this section.

(2) The department shall:
(a) Approve enrollee survey instruments prior to implementation; and
(b) Approve or disapprove an MCO’s enrollee survey tool within fifteen (15) days of receipt of the survey tool.

(3) If an MCO conducts a survey that targets a subpopulation’s perspective or experience with access, treatment, or services, the MCO shall comply with the requirements established in subsection (1)(e) and (f) of this section.

Section 17. Enrollees with Special Health Care Needs. (1) In accordance with 42 C.F.R. 438.208:
(a) The following shall be considered an individual with a special health care need:
1. A child in or receiving foster care or adoption assistance;
2. A homeless individual;
3. An individual with a chronic physical or behavioral illness;
4. A blind or disabled child;
5. An individual who is eligible for SSI benefits; or
6. An adult who is a ward of the Commonwealth in accordance with 910 KAR Chapter 2; and
(b) An MCO shall:
1. Have a process to target enrollees for the purpose of screening and identifying those with special health care needs; and
2. Assess each enrollee identified by the department as having a special health care need to determine if the enrollee needs case management or regular care monitoring.
3. Include the use of appropriate health care professionals to perform an assessment; and
4. Have a treatment plan for an enrollee with a special health care need who has been determined, through an assessment, to need a course of treatment or regular care monitoring.

(2) A treatment plan referenced in subsection (1)(b) of this section shall be developed:
(a) With participation from the enrollee or the enrollee’s legal guardian as referenced in Section 15 of this administrative regulation; and
(b) By the enrollee’s primary care provider, if the enrollee has a primary care provider.

(3) An MCO shall:
(a) 1. Develop materials specific to the needs of an enrollee with a special health care need; and
2. Provide the materials referenced in subparagraph 1. of this paragraph to the enrollee, caregiver, parent, or legal guardian;
(b) Have a mechanism to allow an enrollee identified as having a special health care need to directly access a specialist, as appropriate, for the enrollee’s condition and identified need; and
(c) Be responsible for the ongoing care coordination for an enrollee with a special health care need.

(4) The information referenced in subsection (3)(a) of this section shall include health educational material to assist the enrollee with a special health care need or the enrollee’s caregiver, parent, or legal guardian in understanding the enrollee’s special need.

(5) (a) An enrollee who is a child in foster care or receiving adoption assistance shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DCBS prior to being enrolled with the MCO.
(b) The service plan referenced in paragraph (a) of this subsection shall be used by DCBS and the MCO to determine the enrollee’s medical needs and identify the need for case management;
(c) The MCO shall be available to meet with DCBS at least once a month to discuss the health care needs of the child as identified in the service plan.
(d) If a service plan identifies the need for case management or DCBS requests case management for an enrollee, the foster parent of the child or DCBS shall work with the MCO to develop a case management plan of care.
(e) The MCO shall consult with DCBS prior to developing or modifying a case management plan of care.

(6) (a) An enrollee who is a ward of the Commonwealth shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DAIL prior to being enrolled with the MCO.
(b) If the service plan referenced in paragraph (a) of this subsection identifies the need for case management, the MCO shall work with DAIL or the enrollee to develop a case management plan of care.

Section 18. Second Opinion. An enrollee shall have the right to a second opinion within the MCO’s provider network for a surgical procedure or diagnosis and treatment of a complex or chronic condition.

Section 19. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:
The authorizes: This administrative regulation: This is a new administrative regulation; and establishing Medicaid managed care organization policies and requirements based on a year of experience and analysis.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by clarifying or enhancing Medicaid managed care organization policies and requirements based on a year of experience and analysis.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
(b) The necessity of the amendment to this administrative regulation: No action is required.
(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid recipients who participate with any or all managed care organizations. Medicaid recipients enrolled in managed care (currently there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.
(b) On a continuing basis: No cost is necessary to implement
the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation? The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for which an individual managed care organization’s requirements must meet, as contained in 42 C.F.R. Part 438. This administrative regulation established MCO requirements and policies regarding individuals enrolled in a managed care organization. Those requirements are established in 42 C.F.R. 438.10, 42 C.F.R. 438.52, 42 C.F.R. 438.56, 42 C.F.R. 438.62, 42 C.F.R. 438.66, 42 C.F.R. 438.100-108, 42 C.F.R. 438.224-228 and 42 C.F.R. 438.400 – 408.

2. State compliance standards. KRS 205.520(5) states, “Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary’s power in this respect.” Part I, Section G. Budget Unit 3. a.(b)(17) of House Bill 265 of the 2012 Session of the General Assembly states: “(17) Appeals: An appeal from denial of a service or services provided by a Medicaid managed care organization for medical necessity, or denial, limitation, or termination of a health care service in a case involving a medical or surgical specialty or subspecialty, shall, upon request of the recipient, authorized person, or provider, include a review by a board-eligible or board-certified physician knowledgeable in the appropriate specialty or subspecialty involved in the case of a health care service rendered by a chiropractor or optometrist, in which case, the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky as specified in KRS 304.17A-607(1)(b). The physician reviewer shall not have participated in the initial review and denial of service and shall not be the provider of service or services under consideration in the appeal.”

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation establishes MCO requirements regarding individuals enrolled with a managed care organization. Those requirements include: DMS must approve all material to be distributed by anyone intended to affect a Medicaid recipient’s choice of managed care plan; all written material relating to any plan must be designed to be easily understood; alternative formats must be available to meet the needs of individuals with visual disabilities or limited reading proficiency; written material must be available in every prevalent non-English language in the service area, and oral translation must be available in any non-English language; information required to make a choice about enrollment must be provided in time to help the beneficiary choose; MCOs must make detailed disclosures to enrollees on the provider network and the terms of the plan; all enrollment notices and informational and instructional materials must be in an easily understood form; information concerning providers, enrollee rights and responsibilities, and appeal procedures, and information on covered items and services must be provided; each potential enrollee must be given detailed information about the basic features of the managed care generally, the populations who are required, permitted or excluded from enrollment in a managed care plan; DMS or the MCOs must disclose at least: any Medicaid services that are excluded from coverage; cost sharing requirements; the service area; the names, locations and contact information for participating providers, any non-English languages spoken and whether they are accepting new Medicaid patients; all services provided, the procedures for obtaining services, and the transportation provided. If the managed care entity does not provide counseling or referral for any services on moral or religious grounds, the state must provide the information necessary for enrollees to obtain those services; DMS must assure that all enrollees in Medicaid managed care are notified annually of their right to disenroll; all enrollees have a right to be informed of the same information available to potential enrollees (in greater detail), the amount, duration and scope of services available, their rights with respect to emergency care, the grievance and appeal procedure, the termination of a participating provider and of significant changes in the plan; an MCO must give Medicaid enrollees the right to appeal adverse decisions which include:

1. The denial or limited authorization of a requested service or level of service.

2. The suspension, termination or reduction of a previously authorized service.

3. The failure to provide services in a timely manner, as defined by the State.

4. The denial, in whole or in part, of payment for a service.

5. The failure of an MCO or PIHP to act within the timeframes provided for grievances and appeals.

6. For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; MCOs must have a system which includes an appeal process and access to a state fair hearing process; states, may require the exhaustion of the appeals process before requesting a state fair hearing; an oral request for an appeal must be followed by a written request except when an expedited appeal is requested; MCOs and s must give written notice of an action within specified time limits; the written notice must meet the clarity requirements of 42 C.F.R. §438.10; the notice must state the action taken, give the reason(s) for an action and inform the enrollee of the right and the method to file an appeal, including the procedures for expedited resolution; Notification of decisions to terminate, suspend, or reduce services may be given only if the costs required for Medicaid services under 42 C.F.R. Part 431; any appeal of a denial based on medical necessity or of any other action involving clinical issues must be decided by health care professionals who have appropriate clinical expertise in treating the enrollee’s condition; and all appeals must be decided by individuals who were not involved in the decision or in any previous level of review.

DMS must give individuals a choice of at least two (2) managed care entities or managers. In rural areas, eligible individuals must be permitted a choice of at least two (2) physicians or case managers, to the extent that at least two (2) such individuals are available.; Enrollees may terminate or change plans at any time for cause, and may terminate or change plans without cause during the ninety (90) day period beginning on the date on which the individual receives notice of enrollment and at least once annually thereafter; DMS must establish notice of termination requirements as well as a method for establishing enrollment priorities in the event a managed care entity does not have sufficient capacity to enroll all persons seeking enrollment; MCOs must provide that eligible enrollees may not be held liable for: (1) the debts of the organization in the event of its insolvency; (2) services provided to the enrollee if the organization or its healthcare provider fails to receive payment from the state for such services; or (3) payments to a provider in excess of the amount that would be owed by the enrollee if the organization had directly provided the services; providers and subcontractors may charge enrollees only for any unpa-
id cost-sharing amounts that the state has lawfully imposed, not for the difference between the rate the provider agreed to accept from the MCO and the provider’s usual fee; all marketing materials must be approved by the state and cannot contain false or materially misleading information; an MCO must distribute marketing materials to its entire service area, may not seek to influence an individual’s enrollment with the entity in conjunction with the sale of any other insurance, and must comply with procedures and conditions prescribed by the Health and Human Services (HHS) Secretary to ensure that a potential enrollee is provided accurate oral and written information sufficient to make an informed enrollment decision; and an MCO may not, directly or indirectly, conduct door-to-door, telephone, or other “cold-call” marketing.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care but does not impose additional or stricter requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,198,870,633.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2014 are $3,303,448,347.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

STATEMENT OF EMERGENCY

907 KAR 17:015E

This is a new emergency administrative regulation which is being promulgated concurrently with five (5) other administrative regulations which will establish the Kentucky Medicaid Program managed care organization requirements and policies for every region except region three (3). Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or nearby Jefferson County and its requirements and policies are established in 907 KAR 1:705. One (1) managed care organization has been responsible for managed care in region three (3) since the mid-1990s; however, managed care in that region did not encompass behavioral health services and having one (1) entity does not satisfy the Centers for Medicare and Medicaid Services (CMS) requirement of providing individuals choice of managed care organizations. Consequently, DMS has contracted with four (4) entities – including the entity that has been performing managed care organization functions since the mid-1990s – to be responsible for managed care in region three (3) and the scope of managed care in region three (3) will now include behavioral health services. As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 1:705) and establishing uniform managed care organization requirements and policies for all Medicaid managed care organizations in Kentucky. The six (6) administrative regulations which accomplish this include this administrative regulation; 907 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:010 (managed care organization requirements and policies related to enrollees); 907 KAR 17:020 (managed care organization service and service coverage requirements and policies); 907 KAR 17:025 (managed care organization utilization management and quality requirements and policies); and 907 KAR 17:030 (managed care organization operational and regulatory requirements and policies). DMS is establishing managed care organization requirements across multiple administrative regulations in response to urging from the Administrative Regulation Review Subcommittee (ARRS) and ARRS staff when this administrative regulation was reviewed by the committee earlier this year. Providing a choice of managed care organizations to individuals is necessary to comply with a federal mandate and expanding the scope of managed care in region three (3) to include behavioral health services is also necessary to establish the same managed care benefit package for all Medicaid recipients enrolled in managed care in Kentucky. This action must be implemented on an emergency basis to comply with a federal mandate and to prevent a loss of federal funds as CMS has approved DMS’s revised managed care model - four (4) entities and the scope of services includes behavioral health services – for region three (3). This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office
(New Emergency Administrative Regulation)

907 KAR 17:015E. Managed care organization requirements and policies relating to providers.

RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R. 438


EFFECTIVE: December 21, 2012

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the managed care organization requirements and policies relating to providers.

Section 1. Provider Network. (1) An MCO shall:
(a) Enroll providers of sufficient types, numbers, and specialties in its network to satisfy the:
1. Access and capacity requirements established in Section 2 of this administrative regulation; and
2. Quality requirements established in 907 KAR 17:025;
(b) Attempt to enroll the following providers in its network:
1. A teaching hospital;
2. A rural health clinic;
3. The Kentucky Commission for Children with Special Health Care Needs;
4. A local health department; and
5. A community mental health center;
(c) Demonstrate to the department the extent to which it has enrolled providers in its network who have traditionally provided services to Medicaid recipients;
(d) Have at least one (1) FQHC in a region where the MCO operates in accordance with 907 KAR 17:020, if there is an FQHC that is licensed to provide services in the region; and
(e) Engage in an activity that results in suspension, termination, or exclusion from the Medicare or a Medicaid program.

(2) The length of an exclusion, termination, or suspension referenced in subsection (1)(e) of this section shall equal the length of the exclusion, termination, or suspension imposed by the Medicare or a Medicaid program.

(3) If an MCO is unable to enroll a provider specified in subsection (1)(b) or (c) of this section, the MCO shall submit to the department for approval, documentation which supports the MCO’s conclusion that adequate services and service sites as required in Section 2 of this administrative regulation shall be provided without enrolling the specified provider.

(4) If an MCO or the department determines that the MCO’s provider network is inadequate to comply with the access standards established in Section 2 of this administrative regulation for ninety-five (95) percent of the MCO’s enrollees, the MCO shall:
(a) Notify the department; and
(b) Submit a corrective action plan to the department.

(5) A corrective action plan referenced in subsection (4)(b) of this section shall:
(a) Describe the deficiency in detail; and
(b) Identify a specific action to be taken by the MCO to correct the deficiency, including a time frame.

Section 2. Provider Access Requirements. (1) The access standards requirements established in 42 C.F.R. 438.206 through 438.210 shall apply to an MCO.

(2) An MCO shall:
(a) Be credentialed by the MCO in accordance with the standards established in 907 KAR 17:025;
(b) Have and maintain documentation regarding a provider or subcontractor who engages in an activity that results in suspension, termination, or exclusion from the Medicare or a Medicaid program.

(3)(a) An MCO shall make available and accessible to an enrollee:
1. Facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section;
2. Emergency medical services twenty-four (24) hours a day, seven (7) days a week; and
3. Urgent care services within forty-eight (48) hours of request.
(b) A pharmacy delivery site, except for a mail order pharmacy, shall be within thirty (30) miles or thirty (30) minutes of an enrollee’s residence in an urban area; or
(c) A general vision, laboratory, or radiological service shall be within sixty (60) miles or sixty (60) minutes of an enrollee’s residence.

(4)(a) An MCO’s primary care provider delivery site shall be:
1. Three (3) weeks for a regular appointment; or
2. Thirty (30) miles or thirty (30) minutes from an enrollee’s residence in a non-urban area or thirty (30) minutes from an enrollee’s residence in an urban area; or
3. Based on information or records available to the MCO or the department, the enrollee is in an area where travel time exceeds:
   a. Thirty (30) miles or thirty (30) minutes from an enrollee’s residence in an urban area; or
   b. Forty-five (45) miles or forty-five (45) minutes from an enrollee’s residence in a non-urban area.
(b) A dental appointment wait time shall not exceed:
1. Three (3) weeks for a regular appointment; or
2. Forty-five (45) minutes for urgent care.
(c) A dental service shall be within sixty (60) miles or sixty (60) minutes of an enrollee’s residence.

(5) A pharmacy delivery site, except for a mail order pharmacy, shall be within forty-five (45) minutes of an enrollee’s residence.

(6) A pharmacy delivery site, except for a mail order pharmacy, shall not be further than fifty (50) miles from an enrollee’s residence.

(7) A transport time or distance threshold shall not apply to a mail order pharmacy if it shall:
1. Be physically located within the United States of America; and
2. Provide delivery to the enrollee’s residence.

(8) An MCO or the department determines that the MCO’s provider network is inadequate to comply with the access standards established in Section 2 of this administrative regulation for thirty-five (35) percent of the MCO’s enrollees, the MCO shall:
(a) Notify the department; and
(b) Submit a corrective action plan to the department.

(9) A corrective action plan referenced in subsection (8)(b) of this section shall:
(a) Describe the deficiency in detail; and
(b) Identify a specific action to be taken by the MCO to correct the deficiency, including a time frame.

Section 3. MCO Provider Enrollment. (1) A provider enrolled with an MCO shall:
(a) Be credentialed by the MCO in accordance with the standards established in Section 4 of this administrative regulation; and
(b) Be eligible to enroll with the Kentucky Medicaid Program in accordance with 907 KAR 1.672.

(2) An MCO shall:
(a) Enroll a provider in its network if:
1. The provider has an active sanction imposed by the Centers for Medicare and Medicaid Services or a state Medicaid agency; and
2. The provider is not credentialed;
(b) Have and maintain documentation regarding a provider’s qualifications; and
(c) Attempt to enroll the following providers in its network:
1. A teaching hospital;
2. A rural health clinic;
3. The Kentucky Commission for Children with Special Health Care Needs;
4. A local health department; and
5. A community health center;
(c) Demonstrate to the department the extent to which it has enrolled providers in its network who have traditionally provided services to Medicaid recipients;
(d) Have at least one (1) FQHC in a region where the MCO operates in accordance with 907 KAR 17:020, if there is an FQHC that is licensed to provide services in the region; and
(e) Engage in an activity that results in suspension, termination, or exclusion from the Medicare or a Medicaid program.

(2) The length of an exclusion, termination, or suspension referenced in subsection (1)(e) of this section shall equal the length of the exclusion, termination, or suspension imposed by the Medicare or a Medicaid program.

(3) If an MCO is unable to enroll a provider specified in subsection (1)(b) or (c) of this section, the MCO shall submit to the department for approval, documentation which supports the MCO’s conclusion that adequate services and service sites as required in Section 2 of this administrative regulation shall be provided without enrolling the specified provider.

(4) If an MCO or the department determines that the MCO’s provider network is inadequate to comply with the access standards established in Section 2 of this administrative regulation for ninety-five (95) percent of the MCO’s enrollees, the MCO shall:
(a) Notify the department; and
(b) Submit a corrective action plan to the department.

(5) A corrective action plan referenced in subsection (4)(b) of this section shall:
(a) Describe the deficiency in detail; and
(b) Identify a specific action to be taken by the MCO to correct the deficiency, including a time frame.

Section 2. Provider Access Requirements. (1) The access standards requirements established in 42 C.F.R. 438.206 through 438.210 shall apply to an MCO.

(2) An MCO shall:
(a) Be credentialed by the MCO in accordance with the standards established in 907 KAR 17:025;
Section 4. Provider Credentialing and Recredentialing. (1) An MCO shall:

(a) Have policies and procedures that comply with 907 KAR 1:672; KRS 205.560; and 42 C.F.R. 455 Subpart E, 455.400 to 455.470, regarding the credentialing and recredentialing of a provider;

(b) Have a process for verifying a provider’s credentials and malpractice insurance that shall include:
   1. Written policies and procedures for credentialing and recredentialing of a provider;
   2. An evaluation by the governing body or a group or individual to whom the governing body has formally delegated the credentialing function; and
   3. A review of the credentialing policies and procedures by the governing body or its delegate;

(c) Have a credentialing committee that makes recommendations regarding credentialing;

(d) If a provider requires a review by the credentialing committee, based on the MCO’s quality criteria, notify the department of the facts and outcomes of the review;

(e) Have written policies and procedures for:
   1. Excluding, terminating, or suspending a provider; and
   2. Reporting a quality deficiency that results in an exclusion, suspension, or termination of a provider;

(f) Document its monitoring of a provider;

(g) Verify a provider’s qualifications through a primary source that includes:
   1. A current valid license or certificate to practice in the Commonwealth of Kentucky;
   2. A Drug Enforcement Administration certificate and number, if applicable;
   3. If a provider is not board certified, proof of graduation from a medical school and completion of a residency program;
   4. Proof of completion of an accredited nursing, dental, physician assistant, or vision program, if applicable;
   5. If a provider states on an application that the provider is board certified in a specialty, a professional board certification;
   6. A previous five (5) year work history;
   7. A professional liability claims history;
   8. If a provider requires access to a hospital to practice, proof that the provider has clinical privileges and is in good standing at the hospital designated by the provider as the primary admitting hospital;
   9. Malpractice insurance;
   10. Documentation, if applicable, of:
      a. Revocation, suspension, or probation of a state license or Drug Enforcement Agency certificate and number;
      b. Cancellation or suspension of a medical staff privilege;
      c. Sanction or penalty imposed by the United States Department of Health and Human Services or a state Medicaid agency; or
      d. Censure by a state or county professional association; and
   11. The most recent provider information available from the National Practitioner Data Bank;

(h) Obtain access to the National Practitioner Data Bank as part of its credentialing process;

(i) Have:
   1. A process to recredential a provider at least once every three (3) years that shall be in accordance with subsection (3) of this section; and
   2. Procedures for monitoring a provider sanction, a complaint, or a quality issue between a recredentialing cycle;

(j) Have or obtain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line within four (4) years of implementation of this administrative regulation; and

(k) Continuously maintain NCQA accreditation for its Medicaid product line after obtaining the accreditation.

(2) If an MCO subcontracts a credentialing or recredentialing function, the MCO and the subcontractor shall have written policies and procedures for credentialing and recredentialing.

(3) A provider shall complete a credentialing application, in accordance with 907 KAR 1:672, that includes a statement by the provider regarding:

(a) The provider’s ability to perform essential functions of a position, with or without accommodation;

(b) The provider’s lack of current illegal drug use;

(c) The provider’s history of a:
   1. Loss of license or a felony conviction;
   2. Loss or limitation of a privilege; or
   3. Disciplinary action;

(d) A sanction, suspension, or termination by the United States Department of Health and Human Services or a state Medicaid agency;

(e) Clinical privileges and standing at a hospital designated as the primary admitting hospital of the provider;

(f) Malpractice insurance maintained by the provider; and

(g) The correctness and completeness of the application.

(4) The department shall be responsible for credentialing and recredentialing a hospital-based provider.

Section 5. Provider Services. (1) An MCO shall have a provider services function responsible for:

(a) Enrolling, credentialing, recredentialing, and evaluating a provider;

(b) Assisting a provider with an inquiry regarding enrollee status, prior authorization, referral, claim submission, or payment;

(c) Informing a provider of the provider’s rights and responsibilities;

(d) Handling, recording, and tracking a provider grievance and appeal;

(e) Developing, distributing, and maintaining a provider manual;

(f) Provider orientation and training, including:
   1. Medicaid covered services;
   2. EPSDT coverage;
   3. Medicaid policies and procedures;
   4. MCO policies and procedures; and
   5. Fraud, waste, and abuse;

(g) Assisting in coordinating care for a child or adult with a complex or chronic condition;

(h) Assisting a provider with enrolling in the Vaccines for Children Program in accordance with 907 KAR 1:680; and

(i) Providing technical support to a provider regarding the provision of a service.

(2) An MCO’s provider services staff shall:

(a) Be available at a minimum Monday through Friday from 8:00 a.m. to 6:00 p.m. Eastern Time; and

(b) Operate a provider call center.

Section 6. Provider Manual. (1) An MCO shall provide a provider manual to a provider within five (5) working days of enrollment with the MCO.

(2) Prior to distributing a provider manual or update to a provider manual, an MCO shall procure the department’s approval of the provider manual or provider manual update.

(3) The provider manual shall be available in hard copy and on the MCO’s Web site.

Section 7. Provider Orientation and Education. An MCO shall:

(1) Conduct an initial orientation for a provider within thirty (30) days of enrollment with the MCO to include:

(a) Medicaid coverage policies and procedures;

(b) Reporting fraud and abuse;

(c) Medicaid eligibility groups;

(d) The standards for preventive health services;

(e) The special needs of enrollees;

(f) Advance medical directives;

(g) EPSDT services;

(h) Claims submission;

(i) Care management or disease management programs available to enrollees;

(j) Cultural sensitivity;
Section 8. Primary Care Provider Responsibilities. (1) A PCP shall:

(a) Maintain:
   1. Continuity of an enrollee's health care;
   2. A current medical record for an enrollee in accordance with 907 KAR 17:010; and
   3. Formalized relationships with other PCPs to refer enrollees for after-hours care, during certain days, for certain services, or other reasons to extend their practice;

(b) Refer an enrollee for specialty care or other medically necessary services, both in and out of network, if the services are not available within the MCO's network;

(c) Discuss advance medical directives with an enrollee;

(d) Provide primary and preventive care, including EPSDT services;

(e) Refer an enrollee for a behavioral health service if clinically indicated; and

(f) Have an after-hours phone arrangement that ensures that a PCP or a designated medical practitioner returns the call within thirty (30) minutes.

(2) An MCO shall monitor a PCP to ensure compliance with the requirements established in this section.

Section 9. Provider Discrimination. An MCO shall:

(1) Comply with the anti-discrimination requirements established in:

(a) 42 U.S.C. 1396u-2(b)(7);

(b) 42 C.F.R. 438.12; and

(c) KRS 304.17A-2(b)(7);

(2) Provide written notice to a provider denied participation in the MCO's network stating the reason for the denial.

Section 10. Release for Ethical Reasons. An MCO shall:

(1) Not require a provider to perform a treatment or procedure that is contrary to the provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. 438.102;

(2) Not prohibit or restrict a provider from advising an enrollee about health status, medical care, or a treatment;

(a) Whether or not coverage is provided by the MCO; and

(b) If the provider is acting within the lawful scope of practice; and

(3) Have a referral process in place if a provider declines to perform a service because of an ethical reason.

Section 11. Provider Grievances and Appeals. (1) An MCO shall have written policies and procedures for the filing of a provider grievance or appeal.

(2) A provider shall have the right to file:

(a) A grievance with an MCO; or

(b) An appeal with an MCO regarding:
   1. A provider payment issue; or
   2. A contractual issue.

(3) A provider grievance or appeal shall be resolved within thirty (30) calendar days.

(b) A. If a grievance or appeal is not resolved within thirty (30) days, an MCO shall request a fourteen (14) day extension from the provider.

2. The provider shall approve the extension request from the MCO.

(c) If a provider requests an extension, the MCO shall approve the extension.

Section 12. Medical Records. (1) An MCO shall:

(a) Have a process to systematically review provider medical records to ensure compliance with the medical records standards established in this section.

(b) An enrollee medical record shall:

(a) Be legible, current, detailed, organized, and signed by the service provider;

(b) Be kept for at least five (5) years from the date of service unless a federal statute or regulation requires a longer retention period; and

2. If a federal statute or regulation requires a retention period longer than five (5) years, be kept for at least as long as the federally-required retention period;

(c) Include the following minimal detail for an individual clinical encounter:

1. The history and physical examination for the presenting complaint;

2. A psychological or social factor affecting the patient's physical or behavioral health;

3. An unresolved problem, referral, or result from a diagnostic test; and

4. The plan of treatment including:
   a. Medication history, medications prescribed, including the strength, amount, and directions for use and refills;
   b. Therapy or other prescribed regimen; and
   c. Follow-up plans, including consultation, referrals, and return appointment.

(2) A medical chart organization and documentation shall, at a minimum, contain the following:

(a) Enrollee identification information on each page;

(b) Enrollee date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses, and telephone numbers (if applicable); employer (if applicable), school (if applicable), name and telephone number of an emergency contact, consent form, language spoken, and guardianship information (if applicable);

(c) Date of data entry and of the encounter;

(d) Provider's name;

(e) Any known allergies or adverse reactions of the enrollee;

(f) Enrollee's past medical history;

(g) Identification of any current problem;

(h) If a consultation, laboratory, or radiology report is filed in the medical record, the ordering provider's initials or other documentation indicating review;

(i) Documentation of immunizations;

(j) Identification and history of nicotine, alcohol use, or substance abuse;

(k) Documentation of notification of reportable diseases and conditions to the local health department serving the jurisdiction in which the enrollee resides or to the Department for Public Health pursuant to 902 KAR 2:020;

(l) Follow-up visits provided secondary to reports of emergency room care;

(m) Hospital discharge summaries;

(n) Advance medical directives for adults; and

(o) All written denials of service and the reason for each denial.

Section 13. Provider Surveys. (1) An MCO shall:

(a) Conduct an annual survey of provider satisfaction of the quality and accessibility to a service provided by an MCO;

(b) Annually assess the need for conducting other surveys to support quality and performance improvement initiatives;

(c) Submit to the department for approval the survey tool used to conduct the survey referenced in paragraph (a) of this subsection; and

(d) Provide to the department:
   1. A copy of the results of the provider surveys referenced in
paragraph (a) of this subsection;
2. A description of a methodology to be used to conduct sur-
veys;
3. The number and percentage of providers surveyed;
4. Provider survey response rates;
5. Provider survey findings; and
6. Interventions conducted or planned by the MCO related to
activities in this section.
(2) The department shall:
(a) Approve provider survey instruments prior to implementa-
tion; and
(b) Approve or disapprove an MCO’s provider survey tool with-
in fifteen (15) days of receipt of the survey tool.

Section 14. Cost Reporting Information. The department shall
provide to the MCO the calculation of Medicaid allowable costs as
used in the Medicaid Program.

Section 15. Centers for Medicare and Medicaid Services
Approval and Federal Financial Participation. A policy established in
this administrative regulation shall be null and void if the Centers
for Medicare and Medicaid Services:
(1) Denies or does not provide federal financial participation for
the policy; or
(2) Disapproves the policy.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275
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REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This is a new
administrative regulation which establishes Kentucky Medicaid
program managed care organization (MCO) requirements and
policies relating to providers. Previously, those policies were con-
tained in one (1) administrative regulation - (907 KAR 17:005) –
which contained all MCO policies and requirements (excluding
policies related to the MCO operating in region three (3)). Region
three (3) is a sixteen (16) county region which includes Jefferson
County and previously only contained one (1) MCO. A separate
regulation, 907 KAR 1:705, established the requirements and poli-
cies for the lone MCO in region three (3). The contract between
DMS and the lone MCO in region three (3) is expiring and earlier
this year DMS published a request for proposal for bids to perform
MCO responsibilities in region three (3). Through that process
DMS awarded contracts with four (4) entities – including the in-
cumbent entity that was the sole region three (3) entity. As a result
DMS is repealing 907 KAR 1:705 and establishing uniform re-
quirements and policies for MCOs for all regions – one set of re-
quirements and policies. DMS is doing this by addressing MCO
requirements and policies across six (6) administrative regulations
rather than the aforementioned 907 KAR 17:005. DMS is dividing
the policies across multiple regulations in response to urging from the
Administrative Regulation Review Subcommittee when it re-
viewed 907 KAR 17:005 earlier this year. Thus, this is a new ad-
ministrative regulation but it contains policies that were previously
stated in 907 KAR 17:005. Though this is a new administrative
regulation, it does contain a couple of amended policies. The
amendments include clarifying that the Department for Medicaid
Services (DMS) has authority to determine if an MCO’s provider
network is inadequate; and adding a proximity requirement (mi-
leage and time) for enrollee’s access to providers which previously
had no proximity requirement (pharmacies, dentists, general vision,
laboratory and radiological services); and eliminating an enrollee’s
place of employment as a measuring point in determining the
enrollee’s access to providers.
(b) The necessity of this administrative regulation: This admin-
istrative regulation is necessary to establish Medicaid managed
care organization requirements and policies relating to providers.
The amendments are necessary to clarify DMS’s authority in as-
dessing the adequacy of an MCO’s provider network; to establish
provider access requirements (enrollee proximity to providers) for
provider types for which no proximity (distance/time) requirements
existed in order to ensure recipients have reasonable access to
those provider types; and to eliminate an enrollee’s place of em-
ployment as a proximity (to providers) measuring point as this was
impractical as DMS lacks place of employment information for
enrollees (whereas DMS does possess longitudinal and latitudinal
information for enrollee residences and providers.)
(c) How this administrative regulation conforms to the content of
the authorizing statutes: This administrative regulation conforms
to the content of the authorizing statutes by establishing Medicaid
managed care organization requirements and policies relating to
providers. The amended policies conform to the content of the
authorizing statutes by clarifying or improving policies based on a
year of experience and analysis.
(d) How this administrative regulation currently assists or will
assist in the effective administration of the statutes: This adminis-
trative regulation will assist in the effective administration of the
authorizing statutes by establishing Medicaid managed care organ-
ization requirements and policies relating to providers. The
amended policies conform to the content of the authorizing statutes
by clarifying or improving policies based on a year of experience and
analysis.
(2) If this is an amendment to an existing administrative regula-
tion, provide a brief summary of:
(a) How the amendment will change this existing administrative
regulation: This is a new administrative regulation.
(b) The necessity of the amendment to this administrative regula-
tion: This is a new administrative regulation.
(c) How the amendment conforms to the content of the author-
izing statutes: This is a new administrative regulation.
(d) How the amendment will assist in the effective administra-
tion of the statutes: This is a new administrative regulation.
(3) List the type and number of individuals, businesses, organi-
zations, or state and local government affected by this administra-
tive regulation: Medicaid providers who participate with any or all
managed care organizations. Medicaid recipients enrolled in ma-
naged care (currently there are over 700,000 such individuals) and
the four (4) managed care organizations providing Medicaid cov-
ered services under contract with the Commonwealth will be af-
fected by the administrative regulation.
(4) Provide an analysis of how the entities identified in question
(3) will be impacted by either the implementation of this administra-
tive regulation, if new, or by the change, if it is an amendment,
including:
(a) List the actions that each of the regulated entities identified
in question (3) will have to take to comply with this administrative
regulation or amendment: No action is required.
(b) In complying with this administrative regulation or amend-
ment, how much will it cost each of the entities identified in ques-
tion (3). No cost is imposed.
(c) As a result of compliance, what benefits will accrue to the
entities identified in question (3). The administrative regulation
establishes definitions for managed care regulation. Definitions will
benefit the affected entities by providing clarity to terms used in the
Medicaid managed care regulations.
(5) Provide an estimate of how much it will cost to implement
this administrative regulation:
(a) Initially: No cost is necessary to implement the amendment
to this administrative regulation. DMS’s projected managed care
expenditures for state fiscal year (SFY 2013) are $3,198,870,633.
(b) On a continuing basis: No cost is necessary to implement
the amendment to this administrative regulation. DMS’s projected
managed care expenditures for state fiscal year (SFY 2013) are
$3,303,484,347.
(6) What is the source of the funding to be used for the imple-
mentation and enforcement of this administrative regulation: The
sources of revenue to be used for implementation and enforcement
of this administrative regulation are federal funds authorized under
Title XIX of the Social Security Act and state matching funds com-
prised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirect-ly increases any fees.

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which may be available and those requirements are contained in 42 C.F.R. Part 438. This administrative regulation established MCO provider requirements. Those requirements are established in 42 C.F.R. 438.12, 42 C.F.R. 438.52, and 42 C.F.R. 438.206 through 42 C.F.R. 438.208.

2. State compliance standards. KRS 205.520(3) states, “Fur-ther, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be im-posed or opportunity that may be presented by federal law. Noth-ing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation established MCO provider requirements. Those requirements include the following: MCOs must not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification (if an MCO, PPHP, or PAHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision; MCOs must give allow enrollees to receive services from out-of-network providers in appropriate circum-stances including (1) when the network cannot provide the neces-sary services; (2) the only network provider refuses to perform the service on moral or religious grounds; (3) the recipient's primary care provider or other provider determines that the recipient needs related services that would present unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network; MCOs must give enrollees a free choice of family planning provid-ers; MCOs must demonstrate that it has the capacity to serve the expected enrollment in the service area, including assurances that the organization offers an appropriate range of services and access to preventive and primary care services and maintains a sufficient number, mix, and geographic distribution of service provid-ers; MCOs must met access standards including:

1. Timely access to care and services, taking into account the urgency of the need for services.

2. Hours of operation for network providers that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

3. Services available 24 hours a day, 7 days a week, when medically necessary;

4. Direct access for female enrollees to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care ser-vices - this is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist;

5. Second opinion from a qualified health care professional

with the network, or arrangements for the enrollee to obtain one outside the network, at no cost to the enrollee.

6. Participation in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

4. Will this administrative regulation impose stricter require-ments, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change re-lates to provision of managed care but does not impose additional or stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A managed care method of administering the program is being implemented but stricter requirements are not imposed. A managed care pro-gram is not federally mandated for Medicaid programs.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by govern-ment entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or au-thorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation gen-erate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation gen-erate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this amended administra-tive regulation. DMS's projected managed care expenditures for SFY 2013 are $3,198,870,633.

(d) How much will it cost to administer this program for subse-quent years? No cost is necessary to implement this amended administrative regulation. DMS's projected managed care expendi-tures for SFY 2014 are $3,303,448,347.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): Expenditures (+/-): Other Explanation:

STATEMENT OF EMERGENCY
907 KAR 17:020E

This is a new emergency administrative regulation which is being promulgated concurrently with five (5) other administrative regulations which will establish the Kentucky Medicaid Program managed care organization requirements and policies. Currently, there is one administrative regulation (907 KAR 17:005) which establishes Kentucky Medicaid program managed care organiza-tion requirements and policies for every region except region three (3). Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or near Jefferson County and its requirements and policies are established in 907 KAR 17:070. One (1) managed care organization has been responsible for managed care in region three (3) since the mid-1990s; however, managed care in that region did not encompass behavioral health services and having one (1) entity does not satisfy the Centers for Medicare
and Medicaid Services (CMS) requirement of providing individuals choice of managed care organizations. Consequently, DMS has contracted with four (4) entities – including the entity that has been performing managed care organization functions since the mid-1990s – to be responsible for managed care in region three (3) and the scope of managed care in region three (3) will now include behavioral health services. As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 1:705) and establishing uniform managed care organization requirements and policies for all Medicaid managed care organizations in Kentucky. The six (6) administrative regulations which accomplish this include the administrative regulations 907 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:010 (managed care organization requirements and policies related to enrollees); 907 KAR 17:015 (managed care organization requirements and policies related to providers); 907 KAR 17:025 (managed care organization utilization management and quality requirements and policies); and 907 KAR 17:030 (managed care organization operational and related requirements and policies). DMS is establishing managed care organization requirements across multiple administrative regulations in response to urging from the Administrative Regulation Review Subcommittee (ARRS) and ARRS staff when this administrative regulation was reviewed by the committee earlier this year. Providing a choice of managed care organizations to individuals is necessary to comply with a federal mandate and expanding the scope of managed care in region three (3) to include behavioral health services is also necessary to establish the same managed care benefit package for all Medicaid recipients enrolled in managed care in Kentucky. This action must be implemented on an emergency basis to comply with a federal mandate and to prevent a loss of federal funds as CMS has approved DMS’s revised managed care model - four (4) entities and the scope of services includes behavioral health services – for region three (3). This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office
(New Emergency Administrative Regulation)

907 KAR 17:020E. Managed care organization service and service coverage requirements and policies.

RELATES TO: 194A.025(3), 42 U.S.C. 1396m(c), 42 C.F.R. 438


EFFECTIVE: December 21, 2012

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the Medicaid managed care organization service and service coverage requirements and policies.

Section 1. MCO Service Areas. An MCO’s service areas shall be as established in the MCO Service Areas.

Section 2. Covered Services. (1) Except as established in subsection (2) of this section, an MCO shall be responsible for the provision of a covered health service:

(a) Which is established in Title 907 of the Kentucky Adminis-
An MCO shall provide an enrollee under the age of twenty-one (21) years with EPSDT services in compliance with:

(a) 907 KAR 11:034; and
(b) 42 U.S.C. 1396d(xiv).

(2) A provider of an EPSDT service shall meet the requirements established in 907 KAR 11:034.

Section 4. Emergency Care, Urgent Care, and Poststabilization Care. (1) An MCO shall provide to an enrollee:

(a) Emergency care twenty-four (24) hours a day, seven (7) days a week; and
(b) Urgent care within forty-eight (48) hours.

(2) Poststabilization services shall be provided and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e).

Section 5. Maternity Care. An MCO shall:

(1) Have procedures to assure:

(a) Prompt initiation of prenatal care; or
(b) Continuation of prenatal care without interruption for a woman who is pregnant at the time of enrollment;

(2) Provide maternity care that includes:

(a) Prenatal;
(b) Delivery;
(c) Postpartum care; and
(d) Care for a condition that complicates a pregnancy; and

(3) Perform all the newborn screenings referenced in 902 KAR 4:030.

Section 6. Pediatric Interface. (1) An MCO shall:

(a) Have procedures to coordinate care for a child receiving a school-based health service or an early intervention service; and
(b) Monitor the continuity and coordination of care for the child receiving a service referenced in paragraph (a) of this subsection as part of its quality assessment and performance improvement (QAPI) program established in 907 KAR 17:025.

(2) Except when a child’s course of treatment is interrupted by a school break, after-school hours, or summer break, an MCO shall not be responsible for a service referenced in subsection (1)(a) of this section.

Section 7. Pediatric Sexual Abuse Examination. (1) An MCO shall enroll at least one (1) provider in its network who has the capability to perform a forensic pediatric sexual abuse examination.

(2) A forensic pediatric sexual abuse examination shall be conducted for an enrollee at the request of the DCBS.

Section 8. Lock-in Program. (1) An MCO shall have a program to control utilization of:

(a) Drugs and other pharmacy benefits; and
(b) Non-emergency care provided in an emergency setting.

(2)(a) The program referenced in subsection (1) of this section shall be approved by the department.

(b) An MCO shall not be required to use the criteria established in 907 KAR 1:677 for placing an enrollee in the MCO’s lock-in program if:

1. The MCO provides notice to the enrollee, in accordance with the adverse action notice requirements established in 907 KAR 17:010, of being placed in the MCO’s lock-in program; and
2. The enrollee is granted the opportunity to appeal being placed in a lock-in program in accordance with the:
   a. MCO internal appeal process requirements established in 907 KAR 17:010; and
   b. The department’s state fair hearing requirements established in 907 KAR 17:010.

Section 9. Pharmacy Benefit Program. (1) An MCO shall:

(a) Have a pharmacy benefit program that shall have:
   1. A point-of-sale claims processing service;
   2. Prospective drug utilization review;
   3. An accounts receivable process;
   4. Retrospective utilization review services;
   5. Formulary and non-formulary drugs;
   6. A prior authorization process for drugs;
   7. Pharmacy provider relations;
   8. A toll-free call center that shall respond to a pharmacy or a physician prescriber twenty-four (24) hours a day, seven (7) days a week; and
   9. A seamless interface with the department’s management information system;
   (b) Maintain a preferred drug list (PDL);
   (c) Provide the following to an enrollee or a provider:
      1. PDL information; and
      2. Pharmacy cost sharing information; and
   (d) Have a Pharmacy and Therapeutics Committee (P&T Committee), which shall:
      1. Meet periodically throughout the calendar year as necessary; and
      2. Make recommendations to the MCO for changes to the drug formulary.

(2)(a) The department shall comply with the drug rebate collection requirement established in 42 U.S.C. 1396b(m)(2)(A)(xiiiiii).

(b) An MCO shall:

1. Cooperate with the department in complying with 42 U.S.C. 1396b(m)(2)(A)(xiiiiii); and
2. Assist the department in resolving a drug rebate dispute with a manufacturer; and
3. Be responsible for drug rebate administration in a non-pharmacy setting.

(3) An MCO’s P&T committee shall meet and make recommendations to the MCO for changes to the drug formulary.

(4) If a prescription for an enrollee is for a non-preferred drug and the pharmacist cannot reach the enrollee’s primary care provider or the MCO for approval and the pharmacist determines it necessary to provide the prescribed drug, the pharmacist shall:

(a) Provide a seventy-two (72) hour supply of the prescribed drug; or
(b) Provide less than a seventy-two (72) hour supply of the prescribed drug, if the request is for less than a seventy-two (72) hour supply.

(5) Cost sharing imposed by an MCO shall not exceed the cost sharing limits established in 907 KAR 1:604.

Section 10. MCO Interface with the Department Regarding Behavioral Health. An MCO shall:

(1) Meet with the department monthly to discuss:

(a) Serious mental illness and serious emotional disturbance operating definitions;
(b) Priority populations;
(c) Targeted case management and peer support provider certification training and processes;
(d) IMPACT Plus program operations;
(e) Satisfaction survey requirements;
(f) Priority training topics;
(g) Behavioral health services hotline; or
(h) Behavioral health crisis services;
(2) Coordinate:

(a) An IMPACT Plus covered service provided to an enrollee in accordance with 907 KAR 3:030;
(b) With the department:
   1. An enrollee education process for:
      a. Individuals with a serious mental illness; and
      b. Children or youth with a serious emotional disturbance; and
   2. On establishing a collaborative agreement with a:
      a. State-operated or stated-contracted psychiatric hospital; and
      b. Facility that provides a service to an individual with a co-occurring behavioral health and developmental and intellectual disabilities; and
(c) With the department and community mental health centers:
   a. A process for integrating a behavioral health service hotline; and
   (3) Provide the department with proposed materials and protocols for the enrollee education referenced in subsection (2)(b) of this section.
Section 11. Behavioral Health Services. (1) An MCO shall:
(a) Provide a medically necessary behavioral health service to an enrollee in accordance with the access standards established in 907 KAR 17:015; and
(b) Use the DSM-IV multi-axial classification system to assess an enrollee for a behavioral service;
(c) Have an emergency or crisis behavioral health toll-free hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week;
(d) Not operate one (1) hotline to handle both an emergency or crisis call and a routine enrollee call; and
(e) Not impose a maximum call duration limit.
(2) Staff of a hotline referenced in subsection (1)(c) of this section shall:
(a) Communicate in a culturally competent and linguistically accessible manner to an enrollee; and
(b) Include or have access to a qualified behavioral health professional to assess and triage a behavioral health emergency.
(3) A face-to-face emergency service shall be available:
(a) Twenty-four (24) hours a day; and
(b) Seven (7) days a week.

Section 12. Coordination Between a Behavioral Health Provider and a Primary Care Provider. (1) An MCO shall:
(a) Require a PCP to have a screening and evaluation procedure for the detection and treatment of, or referral for, a known or suspected behavioral health problem or disorder;
(b) Provide training to a PCP in its network on:
1. Screening and evaluating a behavioral health disorder;
2. The MCO’s referral process for a behavioral health service;
3. Coordination requirements for a behavioral health service; and
4. Quality of care standards;
(c) Have policies and procedures that shall be approved by the department regarding clinical coordination between a behavioral health service provider and a PCP;
(d) Establish guidelines and procedures to ensure accessibility, availability, referral, and triage to physical and behavioral health care;
(e) Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;
(f) Identify a method to evaluate continuity and coordination of care; and
(g) Include the monitoring and evaluation of the MCO’s compliance with the requirements established in paragraphs (a) to (f) of this subsection in the MCO’s quality improvement plan.
(2) With consent from an enrollee or the enrollee’s legal guardian, an MCO shall require a behavioral health service provider to:
(a) Refer an enrollee with a known or suspected and untreated physical health problem or disorder to their PCP for examination and treatment; and
(b) Send an initial and quarterly summary report of an enrollee’s behavioral health status to the enrollee’s PCP.

Section 13. Court-Ordered Psychiatric Services. (1) An MCO shall:
(a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-one (21) and over the age of sixty-five (65) who has been ordered to receive the service by a court of competent jurisdiction under the provisions of KRS Chapters 202A and 645;
(b) Not deny, reduce, or negate the medical necessity of an inpatient psychiatric service provided pursuant to a court-ordered commitment for an enrollee under the age of twenty-one (21) or over the age of sixty-five (65);
(c) Coordinate with a provider of a behavioral health service the treatment objectives and projected length of stay for an enrollee committed by a court of law to a state psychiatric hospital; and
(d) Enter into a collaborative agreement with the state-operated or state-contracted psychiatric hospital assigned to the enrollee’s region in accordance with 908 KAR 3:040 and in accordance with the Olmstead decision.
(2) An MCO shall present a modification or termination of a service referenced in subsection (1)(b) of this section to the court with jurisdiction over the matter for determination.
(3)(a) An MCO behavioral health service provider shall:
1. Participate in a quarterly continuity of care meeting with a state-operated or state-contracted psychiatric hospital;
2. Assign a case manager prior to or on the date of discharge of an enrollee from a state-operated or state-contracted psychiatric hospital; and
3. Provide case management services to an enrollee with a severe mental illness and co-occurring developmental disability who is discharged from an:
   a. State-operated or state-contracted psychiatric hospital; or
   b. State-operated nursing facility for individuals with severe mental illness.
(b) A case manager and a behavioral health service provider shall participate in discharge planning to ensure compliance with the Olmstead decision.

Section 14. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:
(1) Denies or does not provide federal financial participation for the policy; or
(2) Disapproves the policy.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.
(3) It may also be obtained online at the department’s Web site at http://www.chfs.ky.gov/dms/incorporated.htm.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email jill.brown@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen
(1) Provide a brief summary of:
(a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) service and service coverage requirements and policies. Previously, those policies were contained in one (1) administrative regulation - (907 KAR 17:005) – which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3)). Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. The only amended policies in this administrative regulation are the inclusion of region three (3) counties for all MCOs; the elimination of the requirement that an MCO’s
lock-in program must be in accordance with DMS’s lock-in regulation (907 KAR 1:677); and eliminating the Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule from being incorporated by reference. MCOs must submit their lock-in programs to DMS for approval but the MCOs’ lock-in programs will no longer be required to be in accordance with DMS’s lock-in regulation. The lock-in program is a program which identifies high utilizers of services and implements controls to ensure that utilization is necessary and not excessive.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization service and service coverage requirements and policies. Amending the service coverage requirements is necessary as the MCO service coverage policies now apply to MCOs operating in region three (3) as DMS is now contracting with four (4) such entities and is repealing the old administrative regulation which applied to the lone entity which was responsible for managed care in region three (3). The lock-in program amendment is necessary to give MCOs more flexibility in designing a lock-in program. Deleting the Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule from being incorporated by reference is necessary as there is no need to incorporate the document by reference into this administrative regulation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization service and service coverage requirements and policies. The amended policy conforms to the content of the authorizing statutes by giving MCOs more flexibility in designing a lock-in program (which also may benefit DMS as DMS can monitor the success of the MCOs’ lock-in programs and learn from the MCOs’ experiences.)

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing Medicaid managed care organization service and service coverage requirements and policies. The amended policy will assist in the effective administration of the authorizing statutes by giving MCOs more flexibility in designing a lock-in program (which also may benefit DMS as DMS can monitor the success of the MCOs’ lock-in programs and learn from the MCOs’ experiences.)

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3)? No cost is imposed.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.

(b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees or funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438. This administrative regulation establishes MCO service and service coverage requirements and policies. Those requirements are established in 42 C.F.R. 438.114, 42 C.F.R. 438.206 through 438.210.

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation establishes MCO service and service coverage requirements. Federal MCO service and service coverage requirements include that MCOs must offer members all services available under the state Medicaid program’s state plan; MCOs must cover emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager; An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of a bodily organ or part; MCOs must cover services needed to evaluate the emergency and stabilize the patient for transfer or discharge and if the treating physician or provider deems necessary, a nonparticipating provider may continue treatment to improve or resolve the patient’s condition if the MCO does not respond to a request for authorization within one hour, no plan physician assumes responsibility for the patient care, or the emergency professional and the plan physician disagree about the appropriate treatment; and MCOs must comply with the maternity and mental health requirements of the Public Health Service Act (PubLNo 94-484) insofar as they apply to a health insurance issuer.
that offers group health insurance coverage.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care but does not impose additional or stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A managed care method of administering the program is being implemented but stricter requirements are not imposed. A managed care program is not federally mandated for Medicaid programs.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,198,870,633.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2014 are $3,303,448,347.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY

907 KAR 17:025E

This is a new emergency administrative regulation which is being promulgated concurrently with five (5) other administrative regulations which will establish the Kentucky Medicaid Program and managed care organization requirements and policies. Currently, there is one administrative regulation (907 KAR 17:005) which establishes Kentucky Medicaid program managed care organization requirements and policies for each region except region three (3). Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or nearby Jefferson County and its requirements and policies are established in 907 KAR 1:705. One (1) managed care organization has been responsible for managed care in region three (3) since the mid-1990s; however, managed care in that region did not encompass behavioral health services and having one (1) entity does not satisfy the Centers for Medicare and Medicaid Services (CMS) requirement of providing individuals choice of managed care organizations. Consequently, DMS has contracted with four (4) entities – including the entity that has been providing managed care organization functions since the mid-1990s – to be responsible for managed care in region three (3) and the scope of managed care in region three (3) will now include behavioral health services. As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 1:705) and establishing uniform managed care organization requirements and policies for all Medicaid managed care organizations in Kentucky. The six (6) administrative regulations which accomplish this include this administrative regulation; 907 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:010 (managed care organization requirements and policies related to enrollees); 907 KAR 17:015 (managed care organization requirements and policies related to providers); 907 KAR 17:020 (managed care organization service and service coverage requirements and policies); and 907 KAR 17:030 (managed care organization operational and related requirements and policies) DMS is establishing managed care organization requirements across multiple administrative regulations in response to urging from the Administrative Regulation Review Subcommittee (ARRS) and ARRS staff when this administrative regulation was reviewed by the committee earlier this year. Providing a choice of managed care organizations to individuals is necessary to comply with a federal mandate and expanding the scope of managed care in region three (3) to include behavioral health services is also necessary to establish the same managed care benefit package for all Medicaid recipients enrolled in managed care in Kentucky. This action must be implemented on an emergency basis to comply with a federal mandate and to prevent a loss of federal funds as CMS has approved the model - four (4) entities and the scope of services includes behavioral health services – for region three (3). This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office

(New Emergency Administrative Regulation)

907 KAR 17:025E. Managed care organization requirements and policies related to utilization management and quality.

RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R. 438


EFFECTIVE: December 21, 2012

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the Medicaid managed care organization requirements and policies relating to utilization management and quality.

Section 1. Utilization Management or UM. (1) An MCO shall:
(a) Have a utilization management program that shall:
1. Meet the requirements established in 42 C.F.R. Parts 431, 438, and 456, and the private review agent requirements of KRS 304.17A, as applicable;
2. Identify, define, and specify the amount, duration, and scope of each service that the MCO is required to offer;
3. Review, monitor, and evaluate the appropriateness and medical necessity of care and services;
4. Identify and describe the UM mechanisms used to:
   a. Detect the under or over utilization of services; and
   b. Act after identifying under utilization or over utilization of
5. Have a written UM program description in accordance with subsection (2) of this section; and

6. Be evaluated annually by the:
   a. MCO, including an evaluation of clinical and service outcomes; and
   b. Department;
   (b) Adopt nationally-recognized standards of care and written criteria that shall be:
      1. Based upon sound clinical evidence, if available, for making utilization decisions; and
   2. Approved by the department;
   (c) Include physicians and other health care professionals in the MCO network in reviewing and adopting medical necessity criteria;
   (d) Have:
      1. A process to review, evaluate, and ensure the consistency with which physicians and other health care professionals involved in UM apply review criteria for authorization decisions;
      2. A medical director who:
         a. Is licensed to practice medicine or osteopathy in Kentucky;
         b. Is responsible for treatment policies, protocols, and decisions; and
         c. Supervises the UM program; and
      3. Written policies and procedures that explain how prior authorization data will be incorporated into the MCO’s quality improvement plan;
   (e) Submit a request for a change in review criteria for authorization decisions to the department for approval prior to implementation;
   (f) Administer or use a CAHPS survey to evaluate and report enrollee satisfaction with the quality of, and access to, care and services in accordance with 907 KAR 17:010; or
   (g) Provide written confirmation of an approval of a request for a service within two (2) business days of providing notification of a decision if:
      1. The initial decision was not in writing; and
      2. Requested by an enrollee or provider;
   (h) If the MCO uses a subcontractor to perform UM, require the subcontractor to have
      written policies, procedures, and a process to review, evaluate, and ensure consistency with which physicians and other health care professionals involved in UM apply review criteria for authorization decisions; and
   (i) Not provide a financial or other type of incentive to an individual or entity that conducts UM activities to deny, limit, or discontinue a medically necessary service to an enrollee pursuant to 42 C.F.R. 432.208, 438.6(h), and 438.210(e).

(2) A UM program description referenced in subsection (1)(a)5. of this section shall:
   a. Outline the UM program’s structure;
   b. Define the authority and accountability for UM activities, including activities delegated to another party; and
   c. Include the:
      1. Scope of the program;
      2. Processes and information sources used to determine service coverage, clinical necessity, and appropriateness and effectiveness;
      3. Policies and procedures to evaluate:
         a. Care coordination;
         b. Discharge criteria;
         c. Site of services;
         d. Levels of care;
         e. Triage decisions; and
         f. Cultural competence of care delivery; and
      4. Processes to review, approve, and deny services as needed.

(3) Only a physician with clinical expertise in treating an enrollee’s medical condition or disease shall be authorized to make a decision to deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested by the enrollee or the enrollee’s treating physician.

(4) A medical necessity review process shall be in accordance with Section 2 of this administrative regulation.

Section 2. Service Authorization and Notice. (1) For the processing of a request for initial or continuing authorization of a service, an MCO shall identify what constitutes medical necessity and establish a written policy and procedure, which includes a timeframe for:
   a. Making an authorization decision; and
   b. If the service is denied or authorized in an amount, duration, or scope which is less than requested, providing a notice to an enrollee and provider acting on behalf of and with the consent of an enrollee.

(2) For an authorization of a service, an MCO shall make a decision:
   a. As expeditiously as the enrollee’s health condition requires; and
   b. Within two (2) business days following receipt of a request for service.

(3) The timeframe for making an authorization decision referenced in subsection (2) of this section may be extended:
   a. By the:
      1. Enrollee, or the provider acting on behalf of and with consent of an enrollee, if the enrollee requests an extension; or
      2. MCO, if the MCO:
         a. Justifies to the department, upon request, a need for additional information and how the extension is in the enrollee’s interest;
         b. Gives the enrollee written notice of the extension, including the reason for extending the authorization decision timeframe and the right of the enrollee to file a grievance if the enrollee disagrees with that decision; and
         c. Makes and carries out the authorization decision as expeditiously as the enrollee’s health condition requires and no later than the date the extension expires; and
   b. Up to fourteen (14) additional calendar days.

(4) If an MCO denies a service authorization or authorizes a service in an amount, duration, or scope which is less than requested, the MCO shall provide a notice:
   a. To the:
      1. Enrollee, in writing, as expeditiously as the enrollee’s condition requires and within two (2) business days of receipt of the request for service; and
      2. Requesting provider, if applicable;
   b. Which shall:
      1. Meet the language and formatting requirements established in 42 C.F.R. 438.404;
      2. Include:
         a. Action the MCO or its subcontractor, if applicable, has taken or intends to take;
         b. Reason for the action;
         c. Right of the enrollee or provider who is acting on behalf of the enrollee to file an MCO appeal;
         d. Right of the enrollee to request a state fair hearing;
         e. Procedure for filing an appeal and requesting a state fair hearing;
      1. Circumstances under which an expedited resolution is available and how to request it; and
      g. Right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services; and
   3. Be provided:
      a. At least ten (10) days before the date of action if the action is a termination, suspension, or reduction of a covered service authorized by the department, department designee, or enrollee’s MCO, except the department may shorten the period of advance notice to five (5) days before the date of action because of probable fraud by the enrollee;
      b. By the date of action for the following:
         i. The death of a member;
         ii. A signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services in which the enrollee understands this will be the result of supplying the information;
      ii. The enrollee’s address is unknown and mail directed to the
enrollee has no forwarding address;
(iv) The enrollee has been accepted for Medicaid services by another local jurisdiction;
(v) The enrollee’s admission to an institution results in the enrollee’s ineligibility for more services;
(vi) The enrollee’s physician prescribes a change in the level of medical care;
(vii) An adverse decision has been made regarding the predmission screening requirements for a nursing facility admission, pursuant to 907 KAR 1:755 and 42 U.S.C. 1396b(3)(F), on or after January 1, 1989; or

(viii) The safety or health of individuals in a facility would be endangered if the enrollee’s health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the enrollee’s urgent medical needs, or an enrollee has not resided in the nursing facility for thirty (30) days;

c. On the date of action, if the action is a denial of payment and the service has not been provided to the member;

d. As expeditiously as the enrollee’s health condition requires and within two (2) business days following receipt of a request;

e. When the MCO carries out its authorization decision, as expeditiously as the enrollee’s health condition requires and no later than the date the extension as identified in subsection (3) of this section expires;

f. If a provider indicates or the MCO determines that following the required timeframe could seriously jeopardize the enrollee’s life or health, or ability to attain, maintain, or regain maximum function, as expeditiously as the enrollee’s health condition requires and no later than two (2) business days after receipt of the request for service; and

g. For an authorization decision not made within the timeframe identified in subsection (2) of this section, on the date the timeframe expires as this shall constitute a denial.

Section 3. Health Risk Assessment. An MCO shall:
(1) After the initial implementation of the MCO program, conduct an initial health risk assessment of each enrollee within ninety (90) days of enrolling the individual if the individual has not been enrolled with the MCO in a prior twelve (12) month period;
(2) Use health care professionals in the health risk assessment process;
(3) Screen an enrollee who it believes to be pregnant within thirty (30) days of enrollment;
(4) If an enrollee is pregnant, refer the enrollee for prenatal care;
(5) Use a health risk assessment to determine an enrollee’s need for:
(a) Care management;
(b) Disease management;
(c) A behavioral health service;
(d) A physical health service or procedure; or
(e) A community service.

Section 4. Care Coordination and Management. An MCO shall:
(1) Have a care coordinator and a case manager who shall:
(a) Arrange, assure delivery of, monitor, and evaluate care, treatment, and services for an enrollee; and
(b) Not duplicate or supplant services provided by a targeted case manager to:
1. Adults with a chronic mental illness pursuant to 907 KAR 1:515; or
2. Children with a severe emotional disability pursuant to 907 KAR 1:525;
(2) Have guidelines for care coordination that shall be approved by the department prior to implementation;
(3) Develop a plan of care for an enrollee in accordance with 42 C.F.R. 438.208;
(4) Have policies and procedures to ensure access to care coordination for a DCBS client or a DAIL client;
(5) Provide information on and coordinate services with the Women, Infants and Children program; and
(6) Provide information to an enrollee and a provider regarding:
(a) An available care management service; and
(b) How to obtain a care management service.

Section 5. Quality Assessment and Performance Improvement (QAPI) Program. An MCO shall:
(1) Have a quality assessment and performance improvement (QAPI) program that shall:
(a) Conform to the requirements of 42 C.F.R. 438 Subpart D, 438.200 to 438.242;
(b) Assess, monitor, evaluate, and improve the quality of care provided to an enrollee;
(c) Provide for the evaluation of:
1. Access to care;
2. Continuity of care;
3. Health care outcomes; and
4. Services provided or arranged for by the MCO;
(d) Demonstrate the linkage of quality improvement (QI) activities to findings from a quality evaluation; and
(e) Be developed in collaboration with input from enrollees;
(2) Submit annually to the department a description of its QAPI program;
(3) Conduct and submit to the department an annual review of the program;
(4) Maintain documentation of:
(a) Enrollee input;
(b) The MCO’s response to the enrollee input;
(c) A performance improvement activity; and
(d) MCO feedback to an enrollee;
(5) Have or obtain within four (4) years of initial implementation
National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line;
(6) If the MCO has obtained NCQA accreditation:
(a) Submit to the department a copy of its current certificate of accreditation with a copy of the complete accreditation survey report; and
(b) Maintain the accreditation;
(7) Integrate behavioral health service indicators into its QAPI program;
(8) Include a systematic, on-going process for monitoring, evaluating, and improving the quality and appropriateness of a behavioral health service provided to an enrollee;
(9) Collect data, monitor, and evaluate for evidence of improvement to a physical health outcome resulting from integration of behavioral health into an enrollee’s care; and
(10) Annually review and evaluate the effectiveness of the QAPI program.

Section 6. Quality Assessment and Performance Improvement Plan. (1) An MCO shall:
(a) Have a written QAPI work plan that:
1. Outlines the scope of activities;
2. Is submitted quarterly to the department; and
3. Sets goals, objectives, and timelines for the QAPI program;
(b) Set new goals and objectives:
1. At least annually; and
2. Based on a finding from:
    a. A quality improvement activity or study;
    b. A survey result;
    c. A grievance or appeal;
    d. A performance measure; or
    e. The external quality review organization;
(c) Be accountable to the department for the quality of care provided to an enrollee;
(d) Obtain approval from the department for its QAPI program and annual QAPI work plan;
(e) Have an accountable entity within the MCO:
1. To provide direct oversight of its QAPI program; and
2. To review reports from the quality improvement committee referenced in paragraph (h) of this subsection;
(f) Review its QAPI program annually;
(g) Modify its QAPI program to accommodate a review finding or concern of the MCO if a review finding or concern occurs;
(h) Have a quality improvement committee that shall:
1. Be responsible for the QAPI program;
2. Be interdisciplinary;
3. Include:
a. Providers and administrative staff; and
b. Health professionals with knowledge of and experience with
individuals with special health care needs;
4. Meet on a regular basis;
5. Document activities of the committee;
6. Make committee minutes and a committee report available
to the department upon request; and
7. Submit a report to the accountable entity referenced in pa-
ragraph (e) of this subsection that shall include:
a. A description of the QAPI activities;
b. Progress on objectives; and
c. Improvements made;
(i) Require a provider to participate in QAPI activities in the
provider agreement or subcontract; and
(j) Provide feedback to a provider or a subcontractor regarding
integration of or operation of a corrective action necessary in a
QAPI activity if a corrective action is necessary.
(2) If a QAPI activity of a provider or a subcontractor is sepa-
rate from an MCO's QAPI program, the activity shall be integrated
into the MCO's QAPI program.

Section 7. QAPI Monitoring and Evaluation. (1) Through its
QAPI program, an MCO shall:
(a) Monitor and evaluate the quality of health care provided to an
enrollee;
(b) Study and prioritize health care needs for performance
measurement, performance improvement, and development of
practice guidelines;
(c) Use a standardized quality indicator:
   1. To assess improvement, assure achievement of at least a
      minimum performance level, monitor adherence to a guideline, and
      identify a pattern of over and under utilization of a service; and
   2. Which shall be:
      a. Supported by a valid data collection and analysis method;
      b. Used to improve clinical care and services;
      (d) Measure a provider performance against a practice guide-
line and a standard adopted by the quality improvement commit-
tee;
   (e) Use a multidisciplinary team to analyze and address data
and systems issues; and
   (f) Have practice guidelines that shall:
      1. Be:
         a. Disseminated to a provider, or upon request, to an enrollee;
         b. Based on valid and reliable medical evidence or consensus
            of health professionals;
      c. Reviewed and updated; and
      d. Used by the MCO in making a decision regarding utilization
         management, a covered service, or enrollee education;
      2. Consider the needs of enrollees; and
      3. Include consultation with network providers.
(2) If an area needing improvement is identified by the QAPI
program, the MCO shall take a corrective action and monitor the
corrective action for improvement.

Section 8. Quality and Member Access Committee. (1) An
MCO shall:
(a) Have a quality and member access committee (QMAC)
composed of:
   1. Enrollees who shall be representative of the enrollee popula-
tion; and
   2. Individuals from consumer advocacy groups or the commu-
   nity who represent the interests of enrollees in the MCO; and
(b) Submit to the department annually a list of enrollee repre-
sentatives participating in the QMAC.
(2) A QMAC shall be responsible for reviewing:
(a) Quality and access standards;
(b) The grievance and appeals process;
(c) Policy modifications needed based on reviewing aggregate
grievance and appeals data;
(d) The member handbook;
(e) Enrollee education materials;
(f) Community outreach activities; and
(g) MCO and department policies that affect enrollees.
(3) The QMAC shall provide the results of its reviews to the
MCO.

Section 9. External Quality Review. (1) In accordance with 42
U.S.C. 1396a(a)(30), the department shall have an independent
external quality review organization (EQRO) annually review the
quality of services provided by an MCO.
(2) An MCO shall:
(a) Provide information to the EQRO as requested to fulfill the
requirements of the mandatory and optional activities required in
42 C.F.R. Parts 433 and 438; and
(b) Cooperate and participate in external quality review activi-
ties in accordance with the protocol established in 42 C.F.R. 438
Subpart E, 438.310 to 438.370.
(3) The department shall have the option of using information
from a Medicare or private accreditation review of an MCO in ac-
cordance with 42 C.F.R. 438.360.
(4) If an adverse finding or deficiency is identified by an EQRO
conducting an external quality review, an MCO shall correct the
finding or deficiency.

Section 10. Health Care Outcomes. An MCO shall:
(1) Comply with the requirements established in 42 C.F.R.
438.240 relating to quality assessment and performance improve-
ment;
(2) Collaborate with the department to establish a set of unique
Kentucky Medicaid managed care performance measures which shall:
   (a) Be aligned with national and state preventive initiatives; and
   (b) Focus on improving health;
(3) In collaboration with the department and the EQRO, devel-
   op a performance measure specific to individuals with special
health care needs;
(4) Report activities on performance measures in the QAPI
work plan established in Section 6 of this administrative regulation;
(5) Submit an annual report to the department after collecting
performance data which shall be stratified by:
   (a) Medicaid eligibility category;
   (b) Race;
   (c) Ethnicity;
   (d) Gender; and
   (e) Age;
   (f) Collect and report HEDIS data annually; and
   (7) Submit to the department:
      (a) The final auditor's report issued by the NCQA certified audit
organization; and
      (b) A copy of the interactive data submission system tool used
by the MCO.

Section 11. Performance Improvement Projects (PIPs). (1) An
MCO shall:
(a) Implement PIPs to address aspects of clinical care and
nonclinical services;
(b) Collaborate with local health departments, behavioral
health agencies, and other community-based health or social ser-
vice agencies to achieve improvements in priority areas;
(c) Initiate a minimum of two (2) PIPs each year with at least
   one (1) PIP relating to physical health and at least one (1) PIP
relating to behavioral health;
   (d) Report on a PIP using standardized indicators;
   (e) Specify a minimum performance level for a PIP; and
   (f) Include the following for a PIP:
      1. The topic and its importance to enrolled members;
      2. Methodology for topic selection;
      3. Goals of the PIP;
      4. Data sources and collection methods;
      5. An intervention; and
      6. Results and interpretations.
(2) A clinical PIP shall address preventive and chronic health-
care needs of enrollees including:
(a) The enrollee population;
(b) A subpopulation of the enrollee population; and
(c) Specific clinical need of enrollees with conditions and ill-
nesses that have a higher prevalence in the enrolled population.
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(3) A nonclinical PIP shall address improving the quality, availability, and accessibility of services provided by an MCO to enrollees and providers.

(4) The department may require an MCO to implement a PIP specific to the MCO if:
   (a) A finding from an EQRO review referenced in Section 9 of this administrative regulation or an audit indicates a need for a PIP; or
   (b) Directed by CMS.

(5) The department shall be authorized to require an MCO to assist in a statewide PIP which shall be limited to providing the department with data from the MCO’s service area.

Section 12. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(a) Denies or does not provide federal financial participation for the policy; or
(b) Disapproves the policy.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email jill.brown@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:
   (a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) requirements and policies relating to utilization management and quality. Previously, those policies were contained in one (1) administrative regulation – 907 KAR 17:005 – which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3)). Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process, DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. The only amended policy in this administrative regulation is the elimination of the MCO reporting requirements as incorporating the material is unnecessary.
   (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to utilization management and quality. The amendment is necessary to prevent the unnecessary incorporation by reference of a document into an administrative regulation.
   (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to utilization management and quality.
   (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to utilization management and quality.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
   (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
   (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
   (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
   (d) How the amendment changes the administrative regulation: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid recipients who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care programs (currently, there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
   (a) The actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.
   (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.

(5) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.

(6) Provide an estimate of how much it will cost to implement this administrative regulation:
   (a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.
   (b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.

(7) Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438. This administrative regulation established MCO utilization management and quality requirements and policies. Quality assessment and performance improvement requirements are established in 42 C.F.R. 438.200 through
438.242. External quality review is another required quality component and those requirements are established in 42 C.F.R. 438.310 through 438.370.

2. State compliance standards. KRS 205.520(3) states, “Further, the power in this respect.”

The following minimum uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation establishes MCO utilization management and quality requirements. Quality assessment and performance improvement requirements are established in 42 C.F.R. 438.200 through 438.242. External quality review is another required quality component and those requirements are established in 42 C.F.R. 438.310 through 438.370. Quality requirements include the following: States must develop and implement a quality assessment and improvement strategy; including: (1) standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care, adequate primary care, and specialized services; (2) examinations of other aspects of care and services directly related to the improvement of quality of care (including grievance procedures and marketing and information standards); (3) procedures for monitoring and evaluating the quality and propriety of care and services, including the submission of quality assurance data; and (4) regular, periodic examinations of the scope and content of the quality improvement strategies. Also, states must provide for an annual external independent review conducted by a qualified independent entity (an external quality review organization or EORO) of the quality outcomes, timeliness, and access to items and services for which the organization is responsible under the contract. The results are available to participating healthcare providers, enrollees, and potential enrollees of the organization in a manner that does not disclose the identity of an individual patient. An EORO must meet the experience and independence criteria at 42 C.F.R. §438.354, which require that there be no financial or contractual relationship between the state agency and the organization.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to a provision of managed care which is not federally mandated but does not impose additional or stricter requirements than the federal managed care organization requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not being imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,198,870.633.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2014 are $3,303,448.347.

STATEMENT OF EMERGENCY
907 KAR 17:030E

This is a new emergency administrative regulation which is being promulgated concurrently with five (5) other administrative regulations which will establish the Kentucky Medicaid Program managed care organization requirements and policies. Currently, there is one administrative regulation (907 KAR 17:005) which establishes Kentucky Medicaid program managed care organization requirements and policies for every region except region three (3). Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or nearby Jefferson County and its requirements and policies are established in 907 KAR 17:705. One (1) managed care organization has been responsible for managed care in region three (3) since the mid-1990s; however, managed care in that region did not encompass behavioral health services and having one (1) entity does not satisfy the Centers for Medicare and Medicaid Services (CMS) requirement of providing individuals choice of managed care organizations. Consequently, DMS has contracted with four (4) entities – including the entity that has been performing managed care organization functions since the mid-1990s – to be responsible for managed care in region three (3) and the scope of managed care in region three (3) will now include behavioral health services. As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 17:705) and establishing uniform managed care organization requirements and policies for all Medicaid managed care organizations in Kentucky. The six (6) administrative regulations which accompany this administrative regulation include this administrative regulation (907 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:010 (managed care organization requirements and policies related to enrollees); 907 KAR 17:015 (managed care organization requirements and policies related to providers); 907 KAR 17:020 (managed care organization service and service coverage requirements and policies); and 907 KAR 17:025 (managed care organization policies and requirements relating to utilization management and quality.) DMS is establishing managed care organization requirements across multiple administrative regulations in response to urging from the Administrative Regulation Review Subcommittee (ARRS) and ARRS staff when this administrative regulation was reviewed by the committee earlier this year. Providing a choice of managed care organizations to individuals is necessary to comply with a federal mandate and expanding the scope of managed care in region three (3) to include behavioral health services is also necessary to establish the same managed care benefit package for all Medicaid recipients enrolled in managed care in Kentucky. This action must be implemented on an emergency basis to comply with a federal mandate and to prevent a loss of federal funds as CMS has approved DMS’s revised managed care model - four (4) entities and the scope of services include behavioral health services – for region three (3). This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.
VOLUME 39, NUMBER 8 – FEBRUARY 1, 2013

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office
(New Emergency Administrative Regulation)

907 KAR 17:030E. Managed care organization operational and related requirements and policies.

RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R. 438


EFFECTIVE: December 21, 2012

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the Medicaid managed care organization operational and related requirements and policies.

Section 1. Prompt Payment of Claims. (1) In accordance with 42 U.S.C. 1396a(a)(37), an MCO shall have prepaid and post-payment claims review procedures that ensure the proper and efficient payment of claims and management of the program.

(2) An MCO shall:
(a) Comply with the prompt payment provisions established in
   1. 42 C.F.R. 447.45; and
   2. KRS 205.593, KRS 304.14-135, and KRS 304.17A-700 to
      304.17A-730; and
   (b) Notify a requesting provider of a decision to:
      1. Deny a claim; or
      2. Authorize a service in an amount, duration, or scope that is
         less than requested.

(3) The payment provisions in this section shall apply to a payment to:
   (a) A provider within the MCO network; and
   (b) An out-of-network provider.

Section 2. Payments to an MCO. (1) The department shall provide an MCO a per enrollee, per month capitation payment whether or not the enrollee receives a service during the period covered by the payment except for an enrollee whose eligibility is determined due to being unemployed in accordance with 45 C.F.R. 233.100.

(2) The monthly capitation payment for an enrollee whose eligibility is determined due to being unemployed shall be prorated from the date of eligibility.

(3) A capitation rate referenced in subsection (1) of this section shall:
   (a) Meet the requirements of 42 C.F.R. 438.6(c); and
   (b) Be approved by the Centers for Medicare and Medicaid Services.

(4)(a) The department shall apply a risk adjustment to a capitation rate in an amount that shall be budget neutral to the department.
   (b) The department shall use the latest version of the Chronic Illness and Disability Payment System to determine the risk adjustment referenced in paragraph (a) of this subsection.

Section 3. Recoupment of Payment from an Enrollee for Fraud, Waste, or Abuse. (1) If an enrollee is determined to be ineligible for Medicaid through an administrative hearing or adjudication of fraud by the CHFS OIG, the department shall recoup a capitation payment it has made to an MCO on behalf of the enrollee.

(2) An MCO shall request a refund from the enrollee referenced in subsection (1) of this section of a payment the MCO has made to a provider for the service provided to the enrollee.

(3) If an MCO has been unable to collect a refund referenced in subsection (2) of this section within six (6) months, the Commonwealth shall have the right to recover the refund from the enrollee.

Section 4. MCO Administration. An MCO shall have executive management responsible for operations and functions of the MCO that shall include:

(1) An executive director who shall:
   (a) Act as a liaison to the department regarding a contract between the MCO and the department;
   (b) Be authorized to represent the MCO regarding an inquiry pertaining to a contract between the MCO and the department;
   (c) Have decision making authority; and
   (d) Be responsible for following up regarding a contract inquiry or issue;
   (2) A medical director who shall be:
      (a) Responsible for the coordination of behavioral health services provided by the MCO or any of its behavioral health subcontractors;
      (b) Actively involved in all of the MCO’s programs or initiatives relating to behavioral health;
      (c) Available for after-hours consultation;
   (3) A dental director who shall be:
      (a) Licensed by a dental board of licensure in any state;
      (b) Actively involved in all oral health programs of the MCO; and
      (c) Available for after-hours consultation;
   (4)(a) A finance officer who shall oversee the MCO’s budget and accounting systems; and
      (b) An internal auditor who shall ensure compliance with adopted standards and review expenditures for reasonableness and necessity;
   (5) A quality improvement director who shall be responsible for the operation of:
      (a) The MCO’s quality improvement program; and
      (b) A subcontractor’s quality improvement program;
   (6) A behavioral health director who shall be:
      (a) A behavioral health practitioner;
      (b) Actively involved in all of the MCO’s programs or initiatives relating to behavioral health services provided by the MCO or any of its behavioral health subcontractors;
   (7) A case management coordinator who shall be responsible for coordinating and overseeing case management services and continuity of care for MCO enrollees;
   (8) An early and periodic screening, diagnosis, and treatment (EPSDT) coordinator who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for MCO enrollees;
   (9) A foster care and subsidized adoption care liaison who shall serve as the MCO’s primary liaison for meeting the needs of an enrollee who is:
      (a) A child in foster care; or
      (b) A child receiving state-funded adoption assistance;
   (10) A guardianship liaison who shall serve as the MCO’s primary liaison for meeting the needs of an enrollee who is a ward of the Commonwealth;
   (11) A management information systems director who shall oversee, manage, and maintain the MCO’s management information system;
   (12) A program integrity coordinator who shall coordinate, manage, and oversee the MCO’s program integrity functions;
   (13) A pharmacy director who shall coordinate, manage, and oversee the MCO’s pharmacy program;
   (14) A compliance director who shall be responsible for the MCO’s:
      (a) Financial and programmatic accountability, transparency, and integrity; and
      (b) Compliance with:
         1. All applicable federal and state law;
         2. Any administrative regulation promulgated by the department relating to the MCO; and
   3. The requirements established in the contract between the
MCO and the department;

(15) A member services director who shall:
(a) Coordinate communication with MCO enrollees; and
(b) Respond in a timely manner to an enrollee seeking a resolution of a problem or inquiry;

(16) A provider services director who shall:
(a) Coordinate communication with MCO providers and subcontractors; and
(b) Respond in a timely manner to a provider seeking a resolution of a problem or inquiry; and

(17) A claims processing director who shall ensure the timely and accurate processing of claims.

Section 5. Health Care Data Submission and Penalties. (1)(a)
An MCO shall submit an original encounter record and denial encounter record, if any, to the department weekly.

(b) An original encounter record or a denial encounter record shall be considered late if not received by the department within four (4) calendar days from the weekly due date.

Section 6. Program Integrity. An MCO shall comply with:

(1) 42 C.F.R. 438.608; and
(2) 42 U.S.C. 1396a(a)(68).

Section 7. Third Party Liability and Coordination of Benefits. (1)
Medicaid shall be the payer of last resort for a service provided to an enrollee.

(2) An MCO shall:
(a) Exhaust a payment by a third party prior to payment for a service provided to an enrollee;
(b) Be responsible for determining a legal liability of a third party to pay for a service provided to an enrollee;
(c) Actively seek and identify a third party liability resource to pay for a service provided to an enrollee in accordance with 42 C.F.R. 433.138; and
(d) Assure that Medicaid shall be the payer of last resort for a service provided to an enrollee.

(3) In accordance with 907 KAR 1:672; and
(4) If an MCO becomes aware of a third party liability resource after payment for a service provided to an enrollee, the MCO shall seek recovery from the third party resource.

Section 8. Management Information System. (1) An MCO shall:
(a) Have a management information system that shall:
1. Provide support to the MCO operations; and
2. Except as provided in subsection (2) of this section, include a:
a. Member subsystem;
b. Third party liability subsystem;
c. Provider subsystem;
d. Reference subsystem;
e. Claim processing subsystem;
f. Financial subsystem;
g. Utilization and quality improvement subsystem; and
h. Surveillance utilization review subsystem; and
(b) Transmit data to the department in accordance with 42 C.F.R. 438.242.
(2) An MCO’s management information system shall not be required to have the subsystems listed in subsection (1)(a2). of this section if the MCO’s management information system:
(a) Has the capacity to:
1. Capture and provide the required data captured by the subsystems listed in subsection (1)(a2). of this section; and
2. Provide the data in formats and files that shall be consistent with the subsystems listed in subsection (1)(a2). of this section; and
(b) Meets the requirements established in paragraph (a) of this subsection in a way which shall be mapped to the subsystem concept established in subsection (1)(a2). of this section.

(3) If an MCO subcontracts for services, the MCO shall provide guidelines for its subcontractor to the department for approval.

Section 9. Kentucky Health Information Exchange (KHIE). (1)
An MCO shall:
(a) Make an attempt to have a PCP in the MCO’s network connect to KHIE within:
1. One (1) year of enrollment in the MCO’s network; or
2. A timeframe approved by the department if greater than one (1) year;
(b) Encourage a provider in its network to establish connectivity with the KHIE.
(2) The department shall:
(a) Administer an electronic health record incentive payment program; and
(b) Inform an MCO of a provider that has received an electronic health record incentive payment.

Section 10. MCO Qualifications and Maintenance of Records. (1) An MCO shall:
(a) Be licensed by the Department of Insurance as a health maintenance organization or an insurer;
(b) Have a governing body;
(c) Have protection against insolvency in accordance with:
1. 806 KAR 3:190; and
2. 42 C.F.R. 438.116;
(d) Maintain all books, records, and information related to MCO providers, recipients, or recipient services, and financial transactions for:
1. A minimum of five (5) years in accordance with 907 KAR 1:672; and
2. Any additional time period as required by federal or state law; and
(e) Submit a request for disclosure of information subject to open records laws, KRS 61.870 to 61.884, received from the public to the department within twenty-four (24) hours.
(2) Information shall not be disclosed by an MCO pursuant to a request it received pursuant to subsection (1)(e) of this section without prior written authorization from the department.
(3) The books, records, and information referenced in subsection (1)(d) of this section shall be available upon request of a reviewer or auditor during routine business hours at the MCO’s place of operations.
(4) MCO staff shall be available upon request of a reviewer or auditor during routine business hours at the MCO’s place of operations.

Section 11. Prohibited Affiliations. The policies or requirements:
(1) Imposed on a managed care entity in 42 U.S.C. 1396u-2(d)(1) shall apply to an MCO; and
(2) Established in 42 C.F.R. 438.610 shall apply to an MCO.

Section 12. Termination of MCO Participation in the Medicaid Program. If necessary, a contract with an MCO shall be terminated and the termination shall be in accordance with KRS Chapter 45A.
Section 13. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies or does not provide federal financial participation for the policy; or
(2) Disapproves the policy.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email jill.brown@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) operational and related requirements. Previously, those policies were contained in one (1) administrative regulation - (907 KAR 17:005) – which contained MCO provider and requirements (excluding managed care organization requirements) and policies relating to the MCO operating in region three (3). Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. The only amended policy in this administrative regulation is the elimination of the MCO reporting requirements, the Management Information System Requirements, the Third Party Liability/Coordination of Benefits as incorporating the materials is unnecessary.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to utilization management and quality. The amendment is necessary to prevent the unnecessary incorporation by reference of documents into an administrative regulation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to utilization management and quality.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to utilization management and quality.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently, there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.

(b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected Medicaid managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438. This administrative regulation established MCO operational and related requirements.

2. State compliance standards. KRS 205.520(3) states, “Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary’s power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation establishes MCO operational and related requirements and those requirements in-
clude: MCOs are required to make adequate provisions against the risk of insolvency. A provision meets the requirements for a plan if the plan meets the solvency standards established by the state for private plans or is licensed or certified by the state as a risk-bearing entity; recipients must be protected from any liability in case of insolvency or failure to receive payment from the state; an MCO may not affiliate knowingly with individuals debarred, suspended, or otherwise excluded from doing business with the federal government; an MCO may not have such an individual as a director, officer, partner, or person with beneficial ownership of more than five (5) percent of the entity’s equity; an MCO may not have an employment, consulting, or other agreement with such an individual for the provision of items and services that are significant and material to the entity’s obligations under its contract with the state; an MCO may not enter into a contract with any state that does not have in effect conflict-of-interest safeguards with respect to officers and employees of the state with responsibilities relating to contracts with such organizations or to the default enrollment process that are at least as effective as the federal safeguards provided under §27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423); an MCO must require each physician providing services to eligible enrollees have a unique identifier; States must establish standards for a range of intermediate sanctions that a state may impose on plans that: (1) fail to provide medically necessary items and services; (2) impose excessive premiums or charges; (3) discriminate against enrollees of the MCO on the basis of race, color, religion, sex, national origin, age, or mental or physical disability; (4) misrepresent or falsely inform; or (5) fail to comply with the applicable requirements of federal law on payment to Medicaid-participating HMOs regarding physician incentive plans; states may not impose intermediate sanctions against a managed care entity that improperly distributes marketing materials; Intermediate sanctions may consist of civil money penalties; states may terminate a contract with an MCO and enroll the entity’s enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the state plan other than through a managed care entity); the Centers for Medicare and Medicaid Services (CMS) must review and approve all contracts with MCOs; and MCOs pay affiliated healthcare providers for items and services on a timely basis in accordance with federal law deadlines for claims payment unless the healthcare provider and the organization agree to an alternate payment schedule.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care (which is not federally mandated) but does not impose additional or stricter requirements than the federal managed care organization requirements.

5. How justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not being imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,198,870,633.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2014 are $3,303,448,347.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): None.

Expenditures (+/-): None.

Other Explanation:

STATEMENT OF EMERGENCY

921 KAR 2:015E

This emergency administrative regulation is necessary to increase the standards of the need for all levels of care in the State Supplementation Program for persons who are aged, blind, or have a disability due to the federal and state agreement to pass through the Supplemental Security Income 2013 cost of living adjustment. Failure to comply with this agreement jeopardizes the state’s Medicaid funds pursuant to 20 C.F.R. 416.2098. The Social Security Administration notified the Department for Community Based Services of the Supplemental Security Income cost of living adjustment in October 2012. An ordinary administrative regulation would not allow the agency sufficient time to have an administrative regulation in place in order to revise the payment standards effective January 1, 2013. This emergency administrative regulation shall be replaced by an ordinary administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Community Based Services

Division of Family Support

(Emergency Amendment)

921 KAR 2:015E. Supplemental programs for persons who are aged, blind, or have a disability.


STATUTORY AUTHORITY: KRS 194A.050(1), 205.245, 42 U.S.C. 1382e-g

EFFECTIVE: December 21, 2012

NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the cabinet to promulgate administrative regulations necessary under applicable state laws to protect, develop, and maintain the welfare, personal dignity, integrity, and sufficiency of the citizens of the Commonwealth and to operate the programs and fulfill the responsibilities of the cabinet. 42 U.S.C. 1382 authorizes the cabinet to administer a state funded program of supplementation to all former recipients of the Aid to the Aged, Blind and Disabled Program as of December 13, 1973, and who were disadvantaged by the implementation of the Supplemental Security Income Program. KRS 205.245 establishes the mandatory supplementation program and the supplementation to other needy persons who are aged, blind, or have a disability. In addition, any state that makes supplementary payments on or after June 30, 1977, and does not have a pass-along agreement to effect with the Commissioner of the Social Security Administration, formerly a part of the U.S. Department of Health, Education, and Welfare, [Department of Health and Human Services Commissioner in effect] shall be determined by the commissioner to be ineligible for payments under Title XIX of the Social Security Act in accordance
Section 1. Definitions. (1) "Adult" is defined by KRS 209.020(4).
(2) "Aid to the Aged, Blind and Disabled Program" means the former state-funded program for an individual who was aged, blind, or had a disability.
(3) "Department" means the Department for Community Based Services or its designee.
(4) "Elder Shelter Network" means a temporary shelter for a victim of elder abuse.
(5) "Full-time living arrangement" means a residential living status that is seven (7) days a week, not part time.
(6) "Qualified alien" means an alien who, at the time the person applies for, receives, or attempts to receive state supplementation, meets the U.S. citizenship requirements of 907 KAR 1:011.
(7) "Specialized personal care home" means a licensed personal care home that receives funding from the Department for Behavioral Health, Developmental and Intellectual Disabilities to employ a mental health professional who has specialized training in the care of a resident with mental illness or mental retardation.
(8) "Supplemental security income" or "SSI" means a monthly cash payment made pursuant to 42 U.S.C. 1381 to 1383f to the aged, blind, or disabled.

Section 2. Mandatory State Supplementation. (1) A recipient for mandatory state supplementation shall include a former Aid to the Aged, Blind and Disabled Program recipient who became ineligible for SSI due to income but whose special needs entitled the recipient to an Aid to the Aged, Blind and Disabled Program payment of December 1973.
(2) A mandatory state supplementation recipient shall be subject to the same payment requirements as specified in Section 4 of this administrative regulation.
(3) A mandatory state supplementation payment shall be equal to the difference between:
   (a) The Aid to the Aged, Blind and Disabled Program payment for the month of December 1973; and
   (b) 1. The total of the SSI payment; or
      2. The total of the SSI payment and other income for the current month.
(4) A mandatory payment shall discontinue if:
   (a) The needs of the recipient as recognized in December 1973 have decreased; or
   (b) Income has increased to the December 1973 level.
(5) The mandatory payment shall not be increased unless:
   (a) Income as recognized in December 1973 decreases;
   (b) The SSI payment is reduced, but the recipient's circumstances are unchanged; or
   (c) The standard of need as specified in Section 8 of this administrative regulation for a class of recipients is increased.
   (6) If a husband and wife are living together, an income change after September 1974 shall not result in an increased mandatory payment unless total income of the couple is less than December 1973 total income.

Section 3. Optional State Supplementation Program. (1) Except as established in Sections 6, 7, and 8 of this administrative regulation, optional state supplementation shall be available to a person who meets technical requirements and resource limitations of the medically needy program for a person who is aged, blind, or has a disability in accordance with:
   (a) 907 KAR 1:011, Sections 1(7), (8), (5)(6), (6), (7), (13), 10, and 11;
   (b) 907 KAR 1:640, Sections 1(1), (6), (7), (11), 3(4)(a);
   (c) 907 KAR 1:645;
   (d) 907 KAR 1:650, Section 19; and
   (e) 907 KAR 1:660, Sections 1(1), (5), 21(2), (2), (3), and (4).
(2) A person shall apply or reapply for the state supplementation program in accordance with 921 KAR 2:035 and shall be required to:
   (a) Furnish a Social Security number; or
   (b) Apply for a Social Security number, if a Social Security number has not been issued.
   (3) If potential eligibility exists for SSI, an application for SSI shall be mandatory.
   (4) The effective date for state supplementation program approval shall be in accordance with 921 KAR 2:050.

Section 4. Optional State Supplementation Payment. (1) An optional supplementation payment shall be issued in accordance with 921 KAR 2:050 for an eligible individual who:
   (a) Requires a full-time living arrangement;
   (b) Has insufficient income to meet the payment standards specified in Section 8 of this administrative regulation; and
   (c)1. Resides in a personal care home and is eighteen (18) years of age or older in accordance with KRS 216.765(2)(902 KAR 20:036, Section 3(3)(a));
      2. Resides in a family care home and is at least eighteen (18) years of age in accordance with 902 KAR 20:041, Section 3(14); or
      3. Receives caretaker services and is at least eighteen (18) years of age.
   (2) A full-time living arrangement shall include:
      (a) Residence in a personal care home that:
         1. Meets the requirements and provides services established in 902 KAR 20:036; and
         2. Is licensed under KRS 216B.010 to 216B.131;
      (b) Residence in a family care home that:
         1. Meets the requirements and provides services established in 902 KAR 20:041; and
         2. Is licensed under KRS 216B.010 to 216B.131; or
      (c) A situation in which a caretaker is required to be hired to provide care other than room and board.
   (3) A guardian or other payee who receives a state supplementation check for a state supplementation recipient shall:
      (a) Return the check to the Kentucky State Treasurer, the month after the month of:
         1. Discharge to a:
            a. Nursing facility, unless the admission is for temporary medical care as specified in Section 9 of this administrative regulation; or
            b. Residence; or
         2. Death of the state supplementation recipient; and
      (b) Notify a local county department office within five (5) working days of the death or discharge of the state supplementation recipient.
   (4) Failure to comply with subsection (3)(a) of this section may result in prosecution in accordance with KRS Chapter 514.
   (5) If there is no guardian or other payee, a personal care or family care home that receives a state supplementation check for a state supplementation recipient shall:
      (a) Return the check to the Kentucky State Treasurer, the month after the month of:
         1. Discharge to a:
            a. Nursing facility, unless the admission is for temporary medical care as specified in Section 9 of this administrative regulation; or
            b. Residence; or
         2. Death of the state supplementation recipient; and
      (b) Notify a local county department within five (5) working days of the:
         1. Death or discharge of the state supplementation recipient; or
   (6) If a personal care or family care home receives a state supplementation check after voluntary relinquishment of a license, as specified in subsection (5)(b)2 of this section, the personal care or family care home shall return the check to the Kentucky State Treasurer.
   (7) Failure to comply with subsections (5)(a) or (6) of this section may result in prosecution in accordance with KRS Chapter 514.

Section 5. Eligibility for Caretaker Services. (1) Service by a caretaker shall be provided to enable an adult to:
   (a) Remain safely and adequately:
1. At home;
2. In another family setting; or
3. In a room and board situation; and
(b) Prevent institutionalization.

(2) Service by a caretaker shall be provided at regular intervals by:
(a) A live-in attendant; or
(b) One (1) or more persons hired to come to the home.

(3) Eligibility for caretaker supplementation shall be verified annually by the cabinet with the caretaker to establish how:
(a) Often the service is provided;
(b) The service prevents institutionalization; and
(c) Payment is made for the service.

(4) A supplemental payment shall not be made to or on behalf of an otherwise eligible individual if the:
(a) Client is taken daily or periodically to the home of the caretaker; or
(b) Caretaker service is provided by the following persons living with the applicant:
   1. The spouse;
   2. Parent of an adult or minor child who has a disability; or
   3. Adult child of a parent who is aged, blind or has a disability.

Section 6. Resource Consideration. (1) Except as stated in subsection (2) of this section, countable resources shall be determined according to policies for the medically needy in accordance with:
(a) 907 KAR 1:640, Sections 1(1), (6), (7), (11), 3(4)(a);
(b) 907 KAR 1:645;
(c) 907 KAR 1:650, Section 1(9); and
(d) 907 KAR 1:660, Sections 1(1), (5), 2(1), (2), (3), and (4).

(2) An individual or couple shall not be eligible if countable resources exceed the limit of:
(a) $2000 for individual; or
(b) $3000 for couple.

Section 7. Income Considerations. (1) Except as noted in subsections (2) through (8) of this section, income and earned income deductions shall be considered according to the policy for the medically needy in accordance with:
(a) 907 KAR 1:640, Sections 1(1), (6), (7), (11), 3(4)(a);
(b) 907 KAR 1:645;
(c) 907 KAR 1:650, Section 1(9); and
(d) 907 KAR 1:660, Sections 1(1), (5), 2(1), (2), (3), and (4).

(2) The optional supplementation payment shall be determined by:
   (a) Adding:
      1. Total countable income of the applicant or recipient, or applicant or recipient and spouse; and
      2. A payment made to a third party on behalf of an applicant or recipient; and
   (b) Subtracting the total of paragraph (a)1 and 2 of this subsection from the standard of need in Section 8 of this administrative regulation.

(3) Income of an ineligible spouse shall be:
   (a) Adjusted by deducting sixty-five (65) dollars and one-half (1/2) of the remainder from the monthly earnings; and
   (b) Conserved in the amount of one-half (1/2) of the SSI standard for an individual for:
      1. The applicant or recipient; and
      2. Each minor dependent child.

(4) Income of an eligible individual shall not be conserved for the needs of the ineligible spouse or minor dependent child.

(5) Income of a child shall be considered if conserving for the needs of the minor dependent child so the amount conserved does not exceed the allowable amount.

(6) The earnings of the eligible individual and ineligible spouse shall be combined prior to the application of the earnings disregard of sixty-five (65) dollars and one-half (1/2) of the remainder.

(7) If treating a husband and wife who reside in the same personal care or family care home as living apart prevents them from receiving state supplementation, the husband and wife may be considered to be living with each other.

(8) The SSI twenty (20) dollars general exclusion shall not be an allowable deduction from income.[9](a) For a resident in the Elder Shelter Network Program, income and resources of the spouse shall be disregarded for the month of separation.

(b) A third-party payment on behalf of an applicant or recipient made by the Elder Shelter Network Program shall be disregarded for ninety (90) days from the date of admission.

Section 8. Standard of Need. (1) To the extent funds are available, the standard of need is as follows:
(a) For a resident of a personal care home on or after January 1, 2013, $1,230[2012, $1,218];
(b) For a resident of a family care home on or after January 1, 2013, $882[2012, $870]; or
(c) For individuals who receive caretaker services:
   1. A single individual, or an eligible individual with an ineligible spouse who is not aged, blind, or has a disability on or after January 1, 2013, $772[2012, $750];
   2. An eligible couple, both aged, blind, or have a disability and one requiring care on or after January 1, 2013, $1,272[2012, $1,109]; or
   3. An eligible couple, both aged, blind or have a disability and both requiring care on or after January 1, 2013, $1,181[2012, $1,163].

(2)(a) In a couple case, if both are eligible, the couple’s income shall be combined prior to comparison with the standard of need.
(b) One-half (1/2) of the deficit shall be payable to each.
(c) A personal care home shall accept as full payment for cost of care the amount of the standard, based on the living arrangement, minus a sixty (60) dollars personal needs allowance that shall be retained by the client.

(4) A family care home shall accept as full payment for cost of care the amount of the standard, based on the living arrangement, minus a forty (40) dollars personal needs allowance that shall be retained by the client.

Section 9. Temporary Stay in a Medical Facility. (1) An SSI recipient who receives optional or mandatory state supplementation shall have continuation of state supplementation benefits without interruption for the first three (3) full months of medical care in a health care facility if the:
(a) SSI recipient meets eligibility for medical confinement established by 20 C.F.R. 416.212; and
(b) Social Security Administration notifies the department that the admission shall be temporary; and
(c) Purpose shall be to maintain the recipient’s home or other living arrangement during a temporary admission to a health care facility.

(2) A non-SSI recipient who receives mandatory or optional state supplementation shall have continuation of state supplementation benefits without interruption for the first three (3) full months of medical care in a health care facility if:
(a) The non-SSI recipient meets the requirements of subsection (1)(c) of this section;
(b) A physician certifies, in writing, that the non-SSI recipient is not likely to be confined for longer than ninety (90) full consecutive days; and
(c) A guardian or other payee, personal care home, or family care home, receiving a state supplementation check for the state supplementation recipient, provides a local county department office with:
   1. Notification of the temporary admission; and
   2. The physician statement specified in paragraph (b) of this subsection.

(3) A temporary admission shall be limited to the following health care facilities:
(a) Hospital;
(b) Psychiatric hospital; or
(c) Nursing facility.

(4) If a state supplementation recipient is discharged in the month following the last month of continued benefits, the temporary absence shall continue through the date of discharge.

Section 10. Citizenship requirements. An applicant or recipient shall be: 
Section 11. Requirement for Residency. An applicant or recipient shall reside in Kentucky.

Section 12. Mental Illness or Mental Retardation (MI/MR) Supplement Program. (1) A personal care home:
(a) May qualify, to the extent funds are available, for a quarterly supplement payment of fifty (50) cents per diem for a state supplementation recipient in the personal care home's care as of the first calendar day of a qualifying month;
(b) Shall not be eligible for a payment for a Type A Citation that is not corrected; and
(c) Shall meet the following certification criteria for eligibility to participate in the MI/MR Supplement Program:
1. Be licensed in accordance with KRS 216B.010 to 216B.131;
2. Care for a population that is thirty-five (35) percent mental illness or mental retardation and in all of its occupied licensed personal care home beds and who have a:
   a. Primary or secondary diagnosis of mental retardation including mild or moderate, or other ranges of retardation whose needs can be met in a personal care home;
   b. Primary or secondary diagnosis of mental illness excluding organic brain syndrome, senility, chronic brain syndrome, Alzheimers, and similar diagnoses; or
   c. Medical history that includes a previous hospitalization in a psychiatric facility, regardless of present diagnosis;
3. Have a licensed nurse or an individual who has received and successfully completed certified medication technician training on duty for at least four (4) hours during the first or second shift each day;
4. Not decrease staffing hours of the licensed nurse or individual who has successfully completed certified medication technician training in effect prior to July 1990, as a result of this minimum requirement;
5. Be verified by the Office of Inspector General in accordance with Section 14(2) through (4) of this administrative regulation; and
6. File an STS-1, Mental Illness or Mental Retardation (MI/MR) Supplement Program Application for Benefits, with the department by the tenth working day of the first month of the calendar quarter to be eligible for payment in that quarter.
   a. Quarters shall begin in January, April, July and October.
   b. Unless mental illness or mental retardation supplement eligibility is discontinued, a new application for the purpose of program certification shall not be required.
(2) A personal care home shall provide the department with its tax identification number and address as part of the application process.
(3) The department shall provide an STS-2, Mental Illness or Mental Retardation (MI/MR) Supplement Program Notice of Decision to Personal Care Home to a personal care home following:
(a) Receipt of verification from the Office of Inspector General as specified in Section 14(6) of this administrative regulation; and
(b) Approval or denial of an application.
(4) A personal care home shall:
(a) Provide the department with an STS-3, Mental Illness or Mental Retardation (MI/MR) Supplement Program Monthly Report Form that:
1. Lists every resident of the personal care home who was a resident on the first day of the month;
2. Lists the resident's Social Security number; and
3. Annotates the form, in order to maintain confidentiality, as follows with a:
   a. Star indicating a resident has a mental illness or mental retardation diagnosis;
   b. Check mark indicating a resident receives state supplementation; and
   c. Star and a check mark indicating the resident has a mental illness or mental retardation diagnosis and is a recipient of state supplementation; and
(b) Submit the STS-3 to the department on or postmarked by the fifth working day of the month by:
   1. Mail;
   2. Fax; or
   3. Electronically.
(5) The monthly report shall be used by the department for:
(a) Verification as specified in subsection (4)(a) of this section; and
(b) Payment; and
(c) Audit purposes.
(6) (a) A personal care home shall notify the department within ten (10) working days if its mental illness or mental retardation percentage goes below thirty-five (35) percent for all personal care residents.
(b) A personal care home may be randomly audited by the department to verify percentages and payment accuracy.

Section 13. Mental Illness or Mental Retardation Basic Training. (1)(a) To the extent cabinet funds are available to support the training, a personal care home's licensed nurse, or individual who has successfully completed certified medication technician training shall attend the mental illness or mental retardation basic training workshop provided through the Department for Behavioral Health, Developmental and Intellectual Disabilities.
(b) Other staff may attend the basic training workshop in order to assure the personal care home always has at least one (1) certified staff employed for certification purposes.
(2) The mental illness or mental retardation basic training shall be provided through a one (1) day workshop. The following topics shall be covered:
(a) Importance of proper medication administration;
(b) Side effects and adverse medication reactions with special attention to psychotropics;
(c) Signs and symptoms of an acute onset of a psychiatric episode;
(d) Characteristics of each major diagnosis, for example, paranoia, schizophrenia, bipolar disorder, or mental retardation;
(e) Guidance in the area of supervision versus patient rights for the population with a diagnosis of mental illness or mental retardation; and
(f) Instruction in providing a necessary activity to meet the needs of a resident who has a diagnosis of mental illness or mental retardation.
(3) Initial basic training shall:
(a) Include the licensed nurse or the individual who has successfully completed certified medication technician training and may include the owner or operator; and
(b) Be in the quarter during which the STS-1 is filed with the department.
(4) To assure that a staff member who has received basic training is always employed at the personal care home, a maximum of five (5) may be trained during a year.
(a) If staff turnover results in the loss of the licensed nurse or individual who has successfully completed certified medication technician training and four (4) other staff have been trained, the personal care home shall request in writing to the department an exemption of the five (5) staff maximum, in order to train another staff member.
(b) A personal care home shall have on staff a licensed nurse or individual who:
1. Has successfully completed certified medication technician training; and
2.a. Has received mental illness or mental retardation basic training; or
b. Is enrolled in the next scheduled mental illness or mental retardation basic training workshop at the closest location.
(5) The Department for Behavioral Health, Developmental and Intellectual Disabilities may provide advanced level training for a personal care home.
(a) Advanced level training shall be provided through a one (1) day workshop.
(b) Each advanced level workshop shall consist of two (2) sessions per day, and each session shall be three (3) hours in duration.
(c) Each three (3) hour session shall cover a topic appropriate for staff who work with a resident who has a diagnosis of mental illness or mental retardation.
(d) Attendance of an advanced level training workshop shall be
optional.

(6) The Department for Behavioral Health, Developmental and Intellectual Disabilities shall provide within five (5) working days a:
(a) Certificate to direct care staff who complete the training workshop; and
(b) Listing to the department of staff who completed the training workshop.

(7) Unless staff turnover occurs as specified in subsection (4)(a) of this section, the department shall pay twenty-five (25) dollars, to the extent funds are available, to a personal care home:  
(a) That has applied for the MI/MR Supplement Program; and
(b) For each staff member receiving basic or advanced level training up to the maximum of five (5) staff per year.

(8) Attendance of the basic training workshop shall be optional for a specialized personal care home.

Section 14. MI/MR Supplement Program Certification. (1) The Office of the Inspector General shall visit a personal care home to certify eligibility to participate in the MI/MR Supplement Program.  
(a) The personal care home's initial MI/MR Supplement Program Certification Survey:  
1. May be separate from an inspection conducted in accordance with KRS 216.530; and
2. Shall be in effect until the next licensure survey.
(b) After a personal care home's initial MI/MR Supplement Program Certification Survey is completed, the personal care home may complete any subsequent certification survey during the licensure survey as specified in paragraph (a)2 of this subsection.
(c) The department shall notify the Office of Inspector General that the personal care home is ready for an inspection for eligibility.
(2) During the eligibility inspection, the Office of Inspector General shall:
(a) Observe and interview residents and staff; and
(b) Review records to assure the following criteria are met:
1. Except for a specialized personal care home, certification is on file at the personal care home to verify staff's attendance of basic training, as specified in Section 13(1) through (4) of this administrative regulation;
2. The personal care home:
   a. Has certified staff training all other direct care staff through in-service training or orientation regarding the information obtained at the mental illness or mental retardation basic training workshop; and
   b. Maintains documentation of attendance at the in-service training for all direct care staff;
3. Medication administration meets licensure requirements and a licensed nurse or individual who has successfully completed certified medication technician training:
   a. Demonstrates a knowledge of psychotropic drug side effects; and
   b. Is on duty as specified in Section 12(1)(c)3 of this administrative regulation; and
4. An activity is being regularly provided that meets the needs of a resident.

(a) If a resident does not attend a group activity, an activity shall be designed to meet the needs of the individual resident, for example, reading or other activity that may be provided on an individual basis.
(b) An individualized care plan shall not be required for the criteria in clause a. of this subparagraph.

(3) The Office of Inspector General shall review the personal care home copy of the training certification prior to performing a record review during the MI/MR Supplement Program Certification Survey process.

(4) If thirty-five (35) percent of the population is mental illness or mental retardation clients, as specified in Section 12(1)(c)2 of this administrative regulation, on the day of the visit, a personal care home shall be deemed to have an ongoing qualifying percentage effective with month of request for certification as specified in subsection (1)(c) of this section.

(5) If the mental illness or mental retardation population goes below thirty-five (35) percent of all occupied personal care beds in the facility, the personal care home shall notify the department as specified in Section 12(6)(a) of this administrative regulation.

(6) The Office of Inspector General shall provide the department with a completed STS-4, Mental Illness or Mental Retardation (MI/MR) Supplement Certification Survey within fifteen (15) working days of:
(a) Initial survey; or
(b) Inspection in accordance with KRS 216.530.
(7) The Office of Inspector General shall provide a copy of a Type A Citation issued to a personal care home to the department by the fifth working day of each month for the prior month.
(8) The personal care home shall receive a reduced payment for the number of days the Type A Citation occurred on the first administratively feasible quarter following notification by the Office of Inspector General, in accordance with 921 KAR 2:050.

(9) If a criterion for certification is not met, the department shall issue an STS-2 to a personal care home following receipt of the survey by the Office of Inspector General as specified in subsection (6) of this section.

(10) The personal care home shall provide the department with the information requested on the STS-2:
(a) Relevant to unmet certification criteria specified on the STS-4; and
(b) Within ten (10) working days after the STS-2 is issued.
(11) If a personal care home fails to provide the department with the requested information specified in subsection (10) of this section, assistance shall be discontinued or decreased, pursuant to 921 KAR 2:046.
(12) If a personal care home is discontinued from the MI/MR Supplement Program, the personal care home may reapply for certification, by filing an STS-1 in accordance with Section 12(1)(c)6 of this administrative regulation, for the next following quarter.

Section 15. Hearings and Appeals. An applicant or recipient of benefits under a program described in this administrative regulation who is dissatisfied with an action or inaction on the part of the cabinet shall have the right to a hearing under 921 KAR 2:055.

Section 16. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) "STS-1, Mental Illness or Mental Retardation (MI/MR) Supplement Program Application for Benefits", edition 1/09;
(b) "STS-2, Mental Illness or Mental Retardation (MI/MR) Supplement Program Notice of Decision to Personal Care Home", edition 1/09;
(c) "STS-3, Mental Illness or Mental Retardation (MI/MR) Supplement Program Monthly Report Form", edition 1/09; and
(d) "STS-4, Mental Illness or Mental Retardation (MI/MR) Supplement Certification Survey", edition 1/09.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

TERESA C. JAMES, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 11, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Justin Dearinger
(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes a program for supplemental payments to persons requiring care in a personal care or family care home or receiving caretaker services in accordance with KRS 205.245.
(b) The necessity of this administrative regulation: This administrative regulation is needed to establish conditions and requirements regarding the State Supplementation Program and the Mental Illness or Mental Retardation (MI/MR) Supplement Program.
(c) How this administrative regulation conforms to the content
of the authorizing statutes: This administrative regulation conforms to the authorizing statutes through its establishment of a supplemental program for persons who are aged, blind or have a disability and its compliance with an agreement with the Social Security Administration, formerly a part of the U.S. Department of Health, Education, and Welfare, to pass along the Supplemental Security Income (SSI) cost of living adjustment to State Supplementation recipients.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the eligibility requirements and standards of need for the State Supplementation Program for persons who are aged, blind or have a disability.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment to this administrative regulation will increase the standards of need for levels of care in the State Supplementation Program for persons who are aged, blind or have a disability. The increase reflects the cost of living adjustment to be implemented in calendar year 2013 by the Social Security Administration for Supplemental Security Income (SSI) recipients. The amendment also makes technical corrections.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to comply with the agreement between the Commonwealth of Kentucky and the Social Security Administration, formerly a part of the U.S. Department of Health, Education, and Welfare, to pass along the cost of living adjustment in Supplemental Security Income (SSI) benefits to State Supplementation Program recipients. Failure to comply with this agreement jeopardizes the state’s Medicaid funds pursuant to 20 C.F.R. 416.243. The Social Security Administration notified the Department for Community Based Services of the amount of the Supplemental Security Income (SSI) cost of living adjustment in October 2012. Technical corrections were necessary in accordance with KRS Chapter 13A and to reflect enacted legislation and the closure of the Elder Shelter Network.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to authorizing statutes by providing an agreement between Kentucky and the federal government to pass along the cost of living adjustment for Supplemental Security Income (SSI) to State Supplementation Program through an increase in the program’s standards of need for all recipients.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the statutes by passing along the 2013 cost of living adjustment for the Supplemental Security Income (SSI) benefit by modifying the standards of need for all levels of care in the State Supplementation Program and making other technical corrections.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: As of October of 2012, there were 3,577 recipients receiving State Supplementation Program benefits.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: There will be no new action required of regulated entities. Regulated entities will realize an increase in the standards of need for each level of care in the State Supplementation Program.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There will be no cost to the regulated entities or their care providers.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The State Supplementation Program’s standards of need will increase by the 2013 cost of living adjustment implemented for the Supplemental Security Income (SSI) Program by the Social Security Administration. Benefit amounts in the State Supplementation Program are the difference between the applicable standard of need and countable income.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: There will be negligible fiscal impact to the Cabinet for Health and Family Services to implement the mandated pass-through of the 2013 SSI cost of living adjustment.

(b) On a continuing basis: There will be negligible fiscal impact to the Cabinet for Health and Family Services to implement the mandated pass-through of the 2013 SSI cost of living adjustment.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: General Funds/Agency Funds are used to fund the State Supplementation Program.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees, and it does not directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applied, because this administrative regulation will be applied in a like manner statewide.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1382 e-g

2. State compliance standards. KRS 194A.050 (1), 205.245

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1382 e-g

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation does not impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose a stricter standard, or additional or different responsibilities or requirements, than those required by the federal mandate.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Community Based Services will be impacted by this administrative regulation.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.050 (1), 205.245, 42 U.S.C. 1382 e-g

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is in effect: This amendment will not generate additional revenue in the first year.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate any additional revenue in subsequent years.

(c) How much will it cost to administer this program for the first year? No additional costs are necessary to administer this program during the first year.

(d) How much will it cost to administer this program for subse-
quent years? No additional costs are necessary to administer this program during subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:
16 KAR 6:010. Examination prerequisites for teacher certification.

RELATES TO: KRS 161.020, 161.028(1), 161.030(3), (4) STATUTORY AUTHORITY: KRS 161.028(1)(a), 161.030(3), (4) NECESSITY, FUNCTION, AND CONFORMITY: KRS 161.028(1)(a) authorizes the Education Professional Standards Board to establish standards and requirements for obtaining and maintaining a teaching certificate. KRS 161.030(3) and (4) requires the Education Professional Standards Board to select the appropriate assessments required prior to teacher certification. This administrative regulation establishes the examination prerequisites for teacher certification.

Section 1. A teacher applicant for certification shall successfully complete the appropriate tests identified in this administrative regulation prior to Kentucky teacher certification.

Section 2. The Education Professional Standards Board shall require the test or tests and passing scores identified in this section for each new teacher applicant and each teacher seeking an additional certificate. (1) An applicant for Interdisciplinary Early Childhood Education certification (birth to primary) shall take one (1) of the following tests and achieve the corresponding passing score or higher:

(a) "Interdisciplinary Early Childhood Education (0023)" – 166; or

(b) "Interdisciplinary Early Childhood Education (5023)" – 166 [An applicant for Interdisciplinary Early Childhood Education certification (birth to primary) shall take "Interdisciplinary Early Childhood Education (0023)" with a passing score of 166.]

(2)(a) Until August 31, 2012, an applicant for Elementary certification (grades P-5) shall take "Elementary Education: Content Knowledge (0014)" with a passing score of 148; or

(b) Beginning September 1, 2012, an applicant for Elementary certification (grades P-5) shall take "Elementary Education: Content Knowledge (0014)" with the passing score of 148; or

An applicant for certification at the middle school level (grades five (5) through nine (9)) shall take the content test or tests based on the applicant’s content area or areas with the corresponding passing scores as identified in this subsection:

(a) Middle School English and Communications:

1. "Middle School English Language Arts (0049)" - 158; or

2. "Middle School English Language Arts (5049)" - 158;

(b) Middle School Mathematics: "Middle School Mathematics (0069)" - 148;

(c) Middle School Science: "Middle School Science (0439)" - 144; or

(d) Middle School Social Studies:

1. "Middle School Social Studies (0089)" - 149; or

2. "Middle School Social Studies (5089)" - 149.

(4) An applicant for certification at the secondary level (grades eight (8) through twelve (12)) shall take the content test or tests corresponding to the applicant’s content area or areas with the passing scores identified in this subsection:

(a) Biology:

1. "Biology: Content Knowledge (0235)" - 146; or

2. "Biology: Content Knowledge (5235)" - 146;

(b) Chemistry:

1. "Chemistry: Content Knowledge (0245)" - 147; or

2. "Chemistry: Content Knowledge (5245)" – 147;

(c) Earth Science:

1. "Earth and Space Sciences: Content Knowledge (0571)" - 147; or

2. "Earth and Space Sciences: Content Knowledge (5571)" - 147;

(d) English:

1. Until August 31, 2012:

   a. "English Language, Literature and Composition: Content Knowledge (0041)" - 160; and

   b. "English Language, Literature and Composition: Essays (0042)" - 155; or

2. Beginning September 1, 2012, "English Language, Literature and Composition: Content and Analysis (0044)" – 166; or

2. "English Language, Literature and Composition: Content and Analysis (5044)" – 166;

(e) Mathematics:

1. a. "Mathematics: Content Knowledge (0061)" - 125; or

   b. "Mathematics: Content Knowledge (5061)" - 125; and


   (f)(1) Physics: "Physics: Content Knowledge (0265)" - 133; or

   2. "Physics: Content Knowledge (5265)" - 133; or

(g) Social Studies:

1. Until August 31, 2012:

   a. "Social Studies: Content Knowledge (0081)" - 151; and

   b. "Social Studies: Interpretation of Materials (0083)" - 159; or

2. Beginning September 1, 2012, "Social Studies: Content and Interpretation (0086)" – 153; or

   2. Social Studies: Content and Interpretation (5086)" – 153.

(5) An applicant for certification in all grades shall take the content test or tests corresponding to the applicant’s area or areas of specialization identified in this subsection, and, if a passing score is established in this subsection, the applicant shall achieve the passing score or higher:

(a) Art:

1. Until August 31, 2012:

   a. "Art: Content Knowledge (0133)" – 158; and

   b. "Art Making (0131)" - 154; or

2. Beginning September 1, 2012: "Art: Content and Analysis (0135)" – 161;

(b) Chinese: "Chinese (Mandarin): World Language (5665)" – 164;

(c) French: "French: World Language (5174)" - 162; or

(d) German: "German: World Language (5183)" - 163; and

(e) Health: "Health Education (0550)" - 630;

(f) Health and Physical Education:

1. "Health and Physical Education: Content Knowledge (0856)" - 156; and

2. "Physical Education: Movement Forms - Analysis and Design (0092)" - 151;

(g)[44] Integrated Music:

1. Until August 31, 2013:

   a. "Music: Content Knowledge (0113)" - 154; and

   2. "Music: Concepts and Processes (0111)" - 145; or

2. Beginning September 1, 2013, "Music: Content and Analysis (0114)" – 162.

(h)[45] Instrumental Music:

1. Until August 31, 2013:

   a. "Music: Content Knowledge (0113)" - 154; and

   2. "Music: Concepts and Processes (0111)" - 145; or

2. Beginning September 1, 2013, "Music: Content and Analysis (0114)" – 162.

(i)[46] Vocal Music:

1. Until August 31, 2013:

   a. "Music: Content Knowledge (0113)" - 154; and
b.[2] "Music: Concepts and Processes (0111)" - 145; or
2. Beginning September 1, 2013, "Music: Content and Analysis (0114)" - 162.

[1][ii] Latin: "Latin (0601)[0600]" - 166[200];

[k][ii] Physical Education:
1. Until August 31, 2012, "Physical Education: Content Knowledge (0091)" - 147; and
b. "Physical Education: Movement Forms Analysis and Design (0092)" - 151; or
2. Beginning September 1, 2011, "Physical Education: Content and Design (0095)" - 169; or
2. "Physical Education: Content and Design (5095)" - 169;

[2][ii] School Librarian:
1. "Library Media Specialist (0311)" - 156; or
2. "Library Media Specialist (5311)" - 156;

[m][ii] School Psychologist: "School Psychologist (0401)" - 161; or

A person provided in subsection (7) of this section, an applicant for certification for teacher of exceptional children in Communication Disorders, Learning and Behavior Disorders, Hearing Impaired, Hearing Impaired with Sign Proficiency, Visually Impaired, or Moderate and Severe Disabilities shall take the content test or tests based on the applicant's area or areas of specialization with the corresponding passing scores as identified in this subsection:

(a) Communication Disorders:
1.a. Until August 31, 2012, "Education of Exceptional Students: Core Content Knowledge (0353)" - 157; or
b. Beginning September 1, 2012, "Education of Exceptional Students: Core Content Knowledge and Applications (0354)" - 151; or
2. "Special Education: Core Knowledge and Applications (5354)" - 151; and
2.a. Until August 31, 2013, "Education of Deaf and Hard of Hearing Students (0271)" - 167; or
b. Beginning September 1, 2013, "Education of Deaf and Hard of Hearing Students (0272)" - 160;
(c) Hearing Impaired With Sign Proficiency:
1.a. Until August 31, 2012, "Education of Exceptional Students: Core Content Knowledge (0353)" - 157; or
b. Beginning September 1, 2012, "Education of Exceptional Students: Core Content Knowledge and Applications (0354)" - 151; or
2. "Special Education: Core Knowledge and Applications (5354)" - 151; and
2.a. Until August 31, 2013, "Education of Deaf and Hard of Hearing Students (0271)" - 167; or
b. Beginning September 1, 2013, "Education of Deaf and Hard of Hearing Students (0272)" - 160; and
3. One (1) of the following tests with a passing score of Intermediate Level:
   a. "Sign Communication Proficiency Interview (SCPI)"; or
   b. "Educational Sign Skills Evaluation (ESSE)";
   (d) Learning and Behavior Disorders:
   1. Until August 31, 2012, "Education of Exceptional Students: Core Content Knowledge (0353)" - 157; and
   b. "Education of Exceptional Students: Moderate to Mild Disabilities (0542)" - 172; or
2. Beginning September 1, 2011, "Special Education: Core Knowledge and Mild to Moderate Applications (0543)" - 158; or
2. "Special Education: Core Knowledge and Mild to Moderate Applications (5543)" - 158;
(c) Moderate and Severe Disabilities:
1. Until August 31, 2012:
   a. "Education of Exceptional Students: Core Content Knowledge (0353)" - 157; and
   b. "Education of Exceptional Students: Severe to Profound Disabilities (0544)" - 156; or
2. Beginning September 1, 2011, "Special Education: Core Knowledge and Severe to Profound Applications (0545)" - 158; or
(f) Visually Impaired:
1. a. Until August 31, 2012, "Education of Exceptional Students: Core Content Knowledge (0353)" - 157; or
b. Beginning September 1, 2011, "Special Education: Core Knowledge and Applications (0354)" - 151; or
2. "Special Education: Core Knowledge and Applications (5354)" - 151; and
2.a. Until August 31, 2013, "Teaching Students with Visual Impairments (0281)" - 161; or

(7) A holder of an exceptional child certificate in Learning and Behavior Disorders or Moderate and Severe Disabilities who is seeking additional certification for any exceptional children teaching certificate listed in subsection (6) of this section shall not be required to take:

(a) "Education of Exceptional Students: Core Content Knowledge (0353)"; or
(b) "Special Education: Core Knowledge and Applications (0354)"; or
(c) "Special Education: Core Knowledge and Applications (5354)".

(8)(a) Except as provided in paragraph (b) of this subsection, an applicant for Career and Technical Education certification to teach in grades five (5) - twelve (12) shall take the content test or tests corresponding to the applicant's area or areas of specialization as identified in this paragraph, and, if a passing score is established in this paragraph, the applicant shall achieve the passing score or higher:

1. Agriculture: "Agriculture (0700)" - 520;
2. Business and Marketing Education:
   a. "Business Education (0101)" - 154; or
   b. "Business and Marketing Education (5101)" - 154;
3. Family and Consumer Science:
   a. "Family and Consumer Sciences (0121)" - 162; or
   b. "Family and Consumer Sciences (5121)" - 162; or
4. Engineering and Technology Education:
   [a. Until August 31, 2012, "Technology Education (0050)" - 600; or

(b) An applicant for Industrial Education shall take the content test or tests corresponding to the applicant's area or areas of specialization with the passing scores as identified in this subsection:

(a) English as a Second Language: "English as a Second Language (0361)" - 157; or
(b) Speech/Media Communications: "Speech Communication (0221)" - 146; or
(c) Theater: "Theater (0641)[0640]" - 162[486].

(10) An applicant for an endorsement in the following content area or areas shall take the content test or tests based on the applicant's area or areas of specialization with the passing scores as identified in this subsection:

(a) American Sign Language: "American Sign Language Proficiency Interview (ASLPI)" administered by the Gallaudet University - 3;
(b) English as a Second Language: "English to Speakers of Other Languages (0361)" - 157; or
(c) Learning and Behavior Disorders, grades 8 - 12:
1. Until August 31, 2012, "Education of Exceptional Students: Mild to Moderate Disabilities (0542)" - 172; or
2. Beginning September 1, 2011, "Special Education: Core Knowledge and Mild to Moderate Applications (0543)" - 158; or
(d) Literacy Specialist: 1. Until August 31, 2012, Literacy Specialist: Reading Specialist (0301) – 125; or
2. Beginning September 1, 2012, Reading Specialist (0301) – 164;
3. Reading Specialist (5301) – 164;
(e) Gifted Education, grades primary - 12: “Gifted Education (0357)” – 152; or
(f) Reading Primary through Grade 12:
1. Teaching Reading (0204) – 153; or
2. Teaching Reading (5204) – 153.

Section 3. In addition to the content area test or tests established in Section 2 of this administrative regulation, each new teacher shall take the pedagogy test and meet the passing score identified in this section that corresponds to the grade level of certification sought. If a certified teacher is seeking additional certification in any area, the applicant shall not be required to take an additional pedagogy test.

(1) An applicant for Elementary certification (grades primary – 5) shall take one (1) of the following tests and achieve the corresponding passing score or higher:
(a) “Principles of Learning and Teaching: Grades kindergarten – six (6) (0622)” – 160; or
(b) “Principles of Learning and Teaching: Grades kindergarten – six (6) (5622)” – 160. (a) Until August 31, 2012, an applicant for Elementary certification (grades primary – 5) shall take “Principles of Learning and Teaching: Grades Kindergarten – 6 (0522)”, with a passing score of 161; or
(b) Beginning September 1, 2012, an applicant for Elementary certification (grades primary – 5) shall take “Principles of Learning and Teaching: Grades Kindergarten – six (6) (0522)”, with a passing score of 160. (b) Until August 31, 2012, an applicant for Elementary certification (grades primary – 5) shall take “Principles of Learning and Teaching: Grades Kindergarten – six (6) (5622)” with a passing score of 160; or
(b) Beginning September 1, 2012, an applicant for Elementary certification (grades primary – 5) shall take “Principles of Learning and Teaching: Grades Kindergarten – six (6) (0622)”, with a passing score of 160.

(2) An applicant for certification at the middle school level (grades five (5) through nine (9)) shall take one (1) of the following tests and achieve the corresponding passing score or higher:
(a) “Principles of Learning and Teaching: Grades 5 – 9 (5623)” – 160; or
(b) “Principles of Learning and Teaching: Grades 5 – 9 (0623)” – 160. (b) Until August 31, 2012, an applicant for certification at the middle school level (grades five (5) through nine (9)) shall take “Principles of Learning and Teaching: Grades 5 – 9 (5623)”, with a passing score of 161; or
(b) Beginning September 1, 2012, an applicant for certification at the middle school level (grades five (5) through nine (9)) shall take “Principles of Learning and Teaching: Grades 5 – 9 (0623)”, with a passing score of 161.

(3) An applicant for certification at the secondary level (grades eight (8) through twelve (12)) shall take one (1) of the following tests and achieve the corresponding passing score or higher:
(a) “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (0624)” – 160; or
(b) “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (5624)” – 160. (a) Until August 31, 2012, an applicant for certification at the secondary level (grades eight (8) through twelve (12)) shall take “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (0524)”, with a passing score of 161; or
(b) Beginning September 1, 2012, an applicant for certification at the secondary level (grades eight (8) through twelve (12)) shall take “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (5624)”, with a passing score of 160.

(4) An applicant for certification in all grades with a content area identified in Section 2(5) of this administrative regulation shall take one (1) of the following tests and achieve the corresponding passing score or higher:
(a) “Principles of Learning and Teaching: Grades kindergarten – six (6) (0622)” – 160;
(b) “Principles of Learning and Teaching: Grades kindergarten – six (6) (5622)” – 160;
(c) “Principles of Learning and Teaching: Grades 5 – 9 (0623)” – 160;
(d) “Principles of Learning and Teaching: Grades 5 – 9 (5623)” – 160;
(e) “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (0624)” – 160; or
(f) “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (5624)” – 160.

(a) Until August 31, 2012, “Principles of Learning and Teaching: Grades kindergarten – six (6) (0522)”, with a passing score of 161; or
(b) 1. Until August 31, 2012, “Principles of Learning and Teaching: Grades five (5) – nine (9) (0523)”, with a passing score of 161; or
2. Beginning September 1, 2012, an applicant for certification at the secondary level (grades five (5) through nine (9)) shall take “Principles of Learning and Teaching: Grades five (5) – nine (9) (0623)”, with a passing score of 161.
(c) 1. Until August 31, 2012, “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (0524)”, with a passing score of 161; or
2. Beginning September 1, 2012, an applicant for certification at the secondary level (grades five (5) through twelve (12)) shall take “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (0624)”, with a passing score of 160.
(d) “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (0623)” – 160.
(e) “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (0622)” – 160.
(f) “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (5624)” – 160.

(a) 1. Until August 31, 2012, “Principles of Learning and Teaching: Grades kindergarten – six (6) (0522)”, with a passing score of 161; or
(b) 1. Until August 31, 2012, “Principles of Learning and Teaching: Grades five (5) – nine (9) (0523)”, with a passing score of 161; or
2. Beginning September 1, 2012, an applicant for certification at the secondary level (grades five (5) through nine (9)) shall take “Principles of Learning and Teaching: Grades five (5) – nine (9) (0623)”, with a passing score of 161.
(c) 1. Until August 31, 2012, “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (0524)”, with a passing score of 161; or
2. Beginning September 1, 2012, an applicant for certification at the secondary level (grades five (5) through twelve (12)) shall take “Principles of Learning and Teaching: Grades seven (7) – twelve (12) (0624)”, with a passing score of 160.
2. Beginning September 1, 2012, an applicant for certification at the middle school level (grades five (5) through nine (9)) shall take “Principles of Learning and Teaching: Grades 5 – 9 (0623)”, with a passing score of 160; or (c) 1. Until August 31, 2012 “Principles of Learning and Teaching: Grades seven (7) - twelve (12) (0524)”, with a passing score of 161; or 2. Beginning September 1, 2012, an applicant for certification at the secondary level (grades eight (8) through twelve (12)) shall take “Principles of Learning and Teaching: Grades seven (7) - twelve (12) (0524)”, with a passing score of 160.

Section 4. Assessment Recency. (1) A passing score on a test established at the time of administration shall be valid for the purpose of applying for certification for five (5) years from the test administration date. (2) A teacher who fails to complete application for certification to the Education Professional Standards Board within the applicable recency period of the test and with the passing score established at the time of administration shall retake the appropriate test or tests and achieve the appropriate passing score or scores required for certification at the time of application. (3) The test administration date shall be established by the Educational Testing Service or other authorized test administrator.

Section 5. (1) An applicant for initial certification shall take the assessments on a date established by: (a) The Educational Testing Service; or (b) The agency established by the Education Professional Standards Board as the authorized test administrator. (2) An applicant shall authorize test results to be forwarded by the Educational Testing Service, or other authorized test administrator, to the Kentucky Education Professional Standards Board and to the appropriate teacher preparation institution where the applicant received the relevant training. (3)(a) Public announcement of testing dates and locations shall be issued sufficiently in advance of testing dates to permit advance registration. (b) An applicant shall seek information regarding the dates and location of the tests and make application for the appropriate examination prior to the deadline established and sufficiently in advance of anticipated employment to permit test results to be received by the Education Professional Standards Board and processed in the normal certification cycle.

Section 6. An applicant shall pay the appropriate examination fee established by the Educational Testing Service or other authorized test administrator for each relevant test required to be taken.

Section 7. An applicant who fails to achieve at least the minimum score on any of the appropriate examinations may retake the test or tests during one (1) of the scheduled test administrations.

Section 8. The Education Professional Standards Board shall collect data and conduct analyses of the scores and institutional reports provided by the Educational Testing Service or other authorized test administrator to determine the impact of these tests.

CASSANDRA WEBB, Chairperson
APPROVED BY AGENCY: October 15, 2012
FILED WITH LRC: November 1, 2012 at 4 p.m.
CONTACT PERSON: Alicia A. Sneed, Director of Legal Services, Education Professional Standards Board, 100 Airport Road, Third Floor, Frankfort, Kentucky 40601, phone (502) 564-4606, fax (502) 564-7080.

EDUCATION PROFESSIONAL STANDARDS BOARD
(As Amended at ARRS, January 7, 2015)

16 KAR 8:030. Continuing Education Option for certificate renewal and rank change.

RELATES TO: KRS 161.020, 161.028, 161.030, 161.1211

STATUTORY AUTHORITY: KRS 161.020, 161.028(1)(a), (f), (q), 161.030, 161.095, 161.1211

NECESSITY, FUNCTION, AND CONFORMITY: KRS 161.095 requires the Education Professional Standards Board to promulgate an administrative regulation establishing procedures for a teacher to maintain a certificate by successfully completing meaningful continuing education. KRS 161.028(1)(f) and 161.030 authorize the board to issue and renew certification for professional school personnel [in the board], and KRS 161.028(1)(q) authorizes the board to charge reasonable certification fees. KRS 161.1211 establishes certificate ranks and requires the board to issue rank classifications. This administrative regulation establishes the procedures for the continuing education option for certificate renewal and rank change.

Section 1. Procedures for the first and second renewal of the professional teaching certificate established in 16 KAR 2:010 shall require completion of: (1) The continuing education option established in this administrative regulation; or (2) A planned fifth-year program established in 16 KAR 8:020.

Section 2. The Continuing Education Option shall only be used to obtain either Rank II or Rank I.

Section 3. Program Requirements. (1) The continuing education option shall consist of four (4) phases: (a) Phase one (1): Completion of an instructional seminar established in Section 4 of this administrative regulation [as of this administrative regulation] and development of a plan for job-embedded professional development; (b) Phase two (2): Content exploration and research; (c) Phase three (3): Development and completion of a seminar plan; and (d) Phase four (4): Professional demonstration and publication. (2) In addition to the completion of the four (4) phases established in subsection (1)(a) through (d) of this section, a candidate for the Continuing Education Option shall: (a) Develop a leadership project aligned to the job-embedded professional development required by [established in subsection (1)(a) of this section]; and (b) Complete the “Take One!” component for National Board Teacher Certification with a successful score.

Section 4. (1) A candidate for the continuing education option for certificate renewal and rank change shall: (a) Attend a board-approved [a] program orientation meeting; and (b) Successfully complete a board-approved seminar on how to build a plan for job-embedded professional development. (2)(a)1. A school district, group of districts, or Kentucky post-secondary institution with an accredited educator preparation program may make application to the Education Professional Standards Board for approval to sponsor a seminar on how to build a plan for job-embedded professional development. 2. The Education Professional Standards Board may sponsor a seminar on how to build a plan for job-embedded professional development in a district or group of districts in which a seminar is not otherwise offered. (b) The seminar on how to build a plan for job-embedded professional development shall be led by a continuing education option coach. (c) The seminar on how to build a plan for job-embedded professional development may be a blend of: 1. Web-based instruction; and 2. Face-to-face cohort meetings. (d) The Education Professional Standards Board may provide Web-based instruction through an on-line module at www.KYEducators.org. (e) A seminar sponsor shall offer face-to-face cohort meetings at least two (2) times per month during the plan building seminar.
(3) Following completion of phase one (1) of the continuing education option, a seminar sponsor shall continue face-to-face cohort meetings on a monthly basis.

(4) Completion of the first phase of the Continuing Education Option shall allow the candidate to receive first renewal of the candidate’s certificate beginning July 30, 2010.

(5) Payment of seminar tuition.

(a) Tuition for the on-line module provided by the Education Professional Standards Board shall be $150.\[and\]

The on-line module fee shall be paid to the Education Professional Standards Board at the time of enrollment.

(b) Tuition for the cohort meetings shall be $1,100.\[and\]

The cohort meeting fee shall be paid to the board-approved seminar sponsor.

(c) Seminar tuition shall be nonrefundable.

2. A cohort meeting fee may be transferred to another seminar sponsor upon agreement between both sponsors.

(6)(a) Upon completion of the seminar, the Continuing Education Option candidate shall design an individual job-embedded professional development plan.

(b) The job-embedded professional development plan shall:

1. Focus on a professional growth need identified by the teacher with consideration given to the needs identified in the school’s consolidated plan, student assessment results, and community resources;

2. Include goals related to:
   a. Each of the ten (10) Kentucky Teacher Standards established in 16 KAR 1:010;
   b. The Kentucky Teacher Standards Advanced Level Performance in the CEO Professional Development Portfolio Rubric; and
   c. The teacher’s individual professional growth needs established in subparagraph[clause] \[of this paragraph].

3. Include a timeline in which the candidate shall complete all phases of the continuing education option. The timeline shall not:
   a. Be less than eighteen (18) months; or
   b. Be more than four (4) years; and
   c. Be reviewed by the continuing education option coach for the seminar cohort.

(c) The continuing education option coach shall:

1. Review the plans using the CEO Professional Development Plan Scoring Rubric; and

2. Provide guidance to the candidate for submitting the plan to the Education Professional Standards Board for scoring.

(d) The candidate shall submit the plan to the Education Professional Standards Board for review.

2. The candidate may resubmit the plan for an additional scoring if the continuing education scoring team has provided evidence of a deficiency in the plan.

3. The candidate shall submit a scoring fee of $455 to the Education Professional Standards Board with the plan.

4. If a candidate submits a plan for additional scoring, the candidate shall submit a rescoring fee of fifty (50) dollars to the Education Professional Standards Board with the plan.

7(a) The candidate shall participate in a job-embedded professional development experience with documented outcomes that demonstrate the accomplishment of the established goals.

(b) A job-embedded professional development experience shall include a combination of:

1. A minimum of six (6) university graduate credits; or
2. With approval from Education Professional Standards Board shall [a combination of] a minimum of six (6) university graduate or undergraduate content course credits that meet the goals established in the candidate’s job-embedded professional growth plan;
3. Research;
4. Field-experience;
5. Professional development activities;
6. Interdisciplinary networking and consultations; and
7. [The “Take One!” component aligned with the candidate’s areas of certification as established by the National Board of Professional Teaching Standards; and]
8. A leadership project.

8(a) The evidence of accomplishment of the goals identified in the plan shall be documented by the candidate in a portfolio.

(b) The candidate shall present the portfolio to the Education Professional Standards Board for review and scoring.

(c) The documentation in the portfolio shall provide evidence:

1. That all Kentucky teacher standards Advanced Level Performance Indicators, as listed in the CEO Professional Development Portfolio Rubric, have been met;
2. Of the effects on student learning; and
3. Of the professional growth over time in:
   a. Content knowledge;
   b. Instructional and student assessment practices; and
   c. Professional demonstration and publication skills.

(d) The portfolio shall be presented using a variety of media, which may include electronic recorders.

(e) The portfolio shall be submitted to the Education Professional Standards Board at least one (1) year in advance of the expiration date of the teacher’s certificate.

(f) The portfolio shall be submitted in either:
   1. A traditional paper format with other media; or
   2. An electronic format.

(g) A portfolio shall not exceed three (3) four (4) inch binders in size or its electronic equivalent.

Section 5. (1) Initial application for the continuing education option program shall be made through a seminar sponsor approved by the Education Professional Standards Board.

(2) The approved seminar sponsor shall report all enrolled applicants to the Education Professional Standards Board.

Section 6.(1) A team of two (2) scorers approved by the Education Professional Standards Board shall review and score the continuing education portfolio.

(2) The scorers shall be selected by the Education Professional Standards Board in accordance with Section 4(3)(a) from a cadre of educators representing teachers, principals, central office instructional personnel, and higher education faculty.

(3) The two (2) person scoring team shall:
   a. Include a teacher certified in the same grade range and content area as the continuing education option candidate;
   b. Score the candidate’s portfolio using the CEO Professional Development Portfolio Rubric; and
   c. Recommend the teacher for certificate renewal to the Education Professional Standards Board prior to the expiration date of the certificate; or
   2. Report results to the Education Professional Standards Board using the scoring rubric to indicate which standards were not met; and
   d. Receive training [as trained by] the Education Professional Standards Board to score the portfolios in a consistent and reliable manner.

(4)(a) If the two (2) person scoring team cannot reach consensus in the review process, a third scorer shall score the portfolio.

(b) An average of the scores shall determine whether the portfolio contained evidence that the ten (10) Kentucky Teacher [Teaching] Standards for Preparation and Certification established in 16 KAR 1:010 were met.

5(a) If the teacher’s portfolio does not contain evidence that all ten (10) Kentucky Teacher Standards established in 16 KAR 1:010 have been met, the teacher may resubmit a partial portfolio for rescoring, which shall contain documented evidence on the unmet standard or standards.

(b) The rescoring process shall follow the same procedures as the initial scoring process established in this section [of this administrative regulation].

(c) The teacher shall receive feedback from the initial scoring regarding additional evidence that may be needed to show that goals were accomplished and that all Kentucky Teacher Standards established in 16 KAR 1:010 were met.

Section 7. [(4)] A teacher following the continuing education option to the five-year program for certificate renewal and rank change shall complete the program by the end of the second certificate renewal period.

Section 8. Payment of Fee for Scoring the Portfolio. (1) A scoring fee of $1,400 shall be assessed to each continuing education
option candidate.
(2) The fee shall be used to pay expenses for the actual cost of administration of the continuing education option program including the costs associated with the following:
(a) The evaluation of approved seminar provider programs;
(b) Training the continuing education option coaches who lead the seminars;
(c) Training and compensating the portfolio reading team members; and
(d) The initial scoring of the portfolio.
(3) Payment shall be made to the Education Professional Standards Board.
(4) The full fee shall be submitted with the portfolio for scoring.
(5) The initial scoring fee shall provide for one (1) scoring of all parts of the portfolio.
(6)(a) A fee of $140 shall be assessed for each unmet standard that requires rescoring.
(b) The rescoring fee, if applicable, shall be submitted to the Education Professional Standards Board with the revised portfolio.

Section 9. (1) A candidate who submitted a professional development plan prior to July 30, 2010 shall submit a portfolio for scoring to the Education Professional Standards Board on the following schedule:
(a) Candidates enrolled in the Continuing Education Option in calendar year 2005 shall submit the portfolio by January 15, 2010.
(b) Candidates enrolled in the Continuing Education Option in calendar year 2006 shall submit the portfolio by January 15, 2011;
and
(c) Candidates enrolled in the Continuing Education Option in calendar year 2007 shall submit the portfolio by January 15, 2012.
(2) The candidate’s portfolio shall be scored using the rubric in effect when the candidate enrolled in the continuing education option program.
(3) A candidate under this section shall not be charged an additional fee for rescoring a previously submitted portfolio.
(4) The candidate under this section shall be provided an opportunity to participate in a cohort meeting established in Section 4 of this administrative regulation.
(5) The candidate under this section shall be offered coaching by an approved continuing education option coach.

Section 10. (1) Portfolios shall be scored by the Education Professional Standards Board on an annual basis.
(2) A candidate shall have been enrolled in the continuing education option program for at least eighteen (18) months prior to submission of the portfolio to the Education Professional Standards Board for scoring.
(3) A candidate shall submit a portfolio to the Education Professional Standards Board for initial scoring between July 1 and July 15.
(4) The date of portfolio submission shall be either:
(a) The day the portfolio is hand-delivered to the Education Professional Standards Board offices; or
(b) The date of the postmark.
(5)(a) A portfolio that requires rescoring shall be resubmitted during one (1) of the rescoring windows of October 1 through 15 or January 1 through 15.
(b) Portfolios not submitted within the rescoring window shall be resubmitted in accordance with the schedule established in subsection (3) of this section.
(6) All portfolios shall become the property of the Education Professional Standards Board.
(7)(a) The Education Professional Standards Board shall provide electronic tracking of all portfolios to identify cases of plagiarism.
(b) Instances of plagiarism shall be reported to the Education Professional Standards Board for disciplinary action.

Section 10.1. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) "CEO Professional Development Plan Scoring Rubric", 2009;
(b) "CEO Professional Development Portfolio Rubric", 2009;
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Education Professional Standards Board, 100 Airport Road, 3rd Floor, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

FINANCE AND ADMINISTRATION CABINET
Kentucky Teachers’ Retirement System
(As Amended at ARRS, January 7, 2013)
102 KAR 1:310. Benefit eligibility conditions for members providing part-time and substitute services.

RELATES TO: KRS 161.470(6), 161.500, 161.520, 161.620, 161.655, 161.661, 161.663
STATUTORY AUTHORITY: KRS 161.310, 161.612
NECESSITY, FUNCTION AND CONFORMITY: KRS 161.310 requires the Board of Trustees of the Kentucky Teachers’ Retirement System to promulgate administrative regulations for the administration of the funds of the retirement system and for the transaction of business. KRS 161.612 requires the board to adopt eligibility conditions pursuant to [under] which members providing part-time or substitute services may participate in the benefits provided pursuant to [under] KRS 161.520, 161.655, 161.661, and 161.663. This administrative regulation establishes eligibility conditions for members providing part-time or substitute services pursuant to [under] in this section.

Section 1. [Any] member who provides part-time or substitute teaching services and who has never been an annuitant of the retirement system shall be eligible to apply for disability retirement benefits pursuant to KRS 161.520 and survivor benefits provided pursuant to KRS 161.520, only if the member meets the eligibility conditions established in this section.

(1) The member shall have completed at least sixty-nine (69) percent of a full contract year that would be completed by a member employed on a full-time basis in the same position in order to become eligible to apply for disability retirement, and for his or her beneficiary and any survivor eligible to apply for life insurance benefits pursuant to KRS 161.520, 161.655 and 161.663, only if the member meets the eligibility conditions established in this section.

(2) A member who is employed in more than one (1) school district in the same fiscal year shall be required to complete at least sixty-nine (69) percent of the normal school calendar for a certified, full-time teacher in the school district in which the member is employed. Full-time employment shall not require less than the normal school calendar for a certified, full-time teacher in the district in which the member is employed.
(3) The member shall be accredited days by adding his or her total number of hours worked in one (1) fiscal year and dividing that number by the number of hours that are required pursuant to a normal, full-time contract to calculate the number of full-time days. If this calculation results in a fractional number of days, the number shall be rounded down to the next whole number of days.
(4) A member who is employed in more than one (1) school district in the same fiscal year shall be required to complete a number of days at least equal to sixty-nine (69) percent of the school calendar in the district requiring the greatest number of days.
(5) Once the requisite number of days or equivalent days are
worked for one (1) fiscal year, the member shall be eligible to apply for disability retirement, and his or her beneficiary and any survivor shall be eligible to apply for life insurance and survivor benefits, through the end of the next fiscal year immediately succeeding the fiscal year in which the eligibility conditions are met.

(6) For [any] member with less than five (5) years of active service in a position participating in the retirement system, the disabling condition or death shall be the result of a single, traumatic, physical injury directly related to his or her Kentucky Teachers’ Retirement System-covered employment in order to be eligible to apply for disability retirement, and for his or her beneficiary or any survivor to be eligible to apply for life insurance and survivor benefits.

(7) A member with less than five (5) years of service credit in Kentucky Teachers’ Retirement System, who has service credit in Kentucky Retirement Systems, shall not be eligible to apply for disability retirement and shall be eligible only for a refund on his or her account pursuant to [under the conditions of KRS 161.470(6)], unless the member experiences a disabling condition as a result of the conditions required by subsection (6) of this section.

Section 2. [Any] member who is employed part-time in a non-teaching position that requires certification or a four (4) year degree and who has never been an annuitant of the retirement system shall be eligible to apply for disability retirement benefits provided pursuant to KRS 161.661 and 161.663, and his or her beneficiary or any survivor eligible to apply for life insurance benefits provided pursuant to KRS 161.655 and survivor benefits provided pursuant to KRS 161.520, only if the member meets the eligibility conditions established in this section. Full-time employment shall not require less than 220 working days.

(2) If the position does not provide for full-time employment, the member shall be credited with a number of days required for full-time employment in the position in order to become eligible to apply for disability retirement, and for his or her beneficiary and any survivor to be eligible to apply for life insurance and survivor benefits. Employment shall be in a position from which contributions were made to Kentucky Teachers’ Retirement System.

(3) The member shall be accredited days by adding his or her total number of hours worked in one (1) fiscal year and dividing that number by the number of hours that are required under normal full-time conditions established in this section.

(4) A member who is employed by more than one (1) employer in the same fiscal year shall be required to complete at least sixty-nine (69) percent of the number of days required for full-time employment in the position in order to become eligible to apply for disability retirement, and for his or her beneficiary and any survivor to be eligible to apply for life insurance and survivor benefits. Employment shall be in a position from which contributions were made to Kentucky Teachers’ Retirement System.

(5) Once the requisite number of days or equivalent days are worked for one (1) fiscal year, the member shall be eligible to apply for disability retirement, and his or her beneficiary or any survivor shall be eligible to apply for life insurance and survivor benefits, through the end of the next fiscal year immediately succeeding the fiscal year in which the eligibility conditions are met.

(6) For [any] member with less than five (5) years of active service in a position participating in the retirement system, the disabling condition or death shall be the result of a single, traumatic, physical injury directly related to his or her Kentucky Teachers’ Retirement System-covered employment in order to be eligible to apply for disability retirement, and for his or her beneficiary or any survivor to be eligible to apply for life insurance and survivor benefits.

(7) A member with less than five (5) years of service credit in Kentucky Teachers’ Retirement System, who has service credit in Kentucky Retirement Systems, shall not be eligible to apply for disability retirement benefits and shall be eligible only for a refund of his or her account pursuant to the conditions of KRS 161.470(6), unless the member experiences a disabling condition as a result of the conditions required in subsection (6) of this section.

FINANCE AND ADMINISTRATION CABINET
Kentucky Teachers’ Retirement System
(As Amended at ARRS, January 7, 2013)

102 KAR 1:340. Calculation of final average salary [ifwhere] there is a corresponding change in length of employment during any of the final three (3) years immediately prior to retirement.

RELATES TO: KRS 161.220(9)
STATUTORY AUTHORITY: KRS 161.310
NECESSITY, FUNCTION AND CONFORMITY: KRS 161.310(1) requires the board of trustees to promulgate administrative regulations for the administration of the funds of the retirement system and for the transaction of business. KRS 161.220(9) establishes [provides for] the definition of “final average salary” for retirement calculation purposes, which definition—KRS 161.220(9)—limits the amount of increases in salaries that can be included as final average salary [ifwhere] those increases are received for any of the three (3) years of employment immediately prior to retirement, unless. The limitation does not apply when the member experiences a corresponding change in position or in length of employment. This administrative regulation establishes [provides] the method for calculating final average salary [ifwhere] there is a change in length of employment.

RELATES TO: KRS 161.220(9)
STATUTORY AUTHORITY: KRS 161.310
NECESSITY, FUNCTION AND CONFORMITY: KRS 161.310(1) requires the board of trustees to promulgate administrative regulations for the administration of the funds of the retirement system and for the transaction of business. KRS 161.220(9) establishes [provides for] the definition of “final average salary” for retirement calculation purposes, which definition—KRS 161.220(9)—limits the amount of increases in salaries that can be included as final average salary [ifwhere] those increases are received for any of the three (3) years of employment immediately prior to retirement, unless. The limitation does not apply when the member experiences a corresponding change in position or in length of employment. This administrative regulation establishes [provides] the method for calculating final average salary [ifwhere] there is a change in length of employment.

Section 1. [Any] member who receives an increase in salary that exceeds the limits permitted for inclusion as final average salary pursuant to KRS 161.220(9)(b), but experiences a corresponding change in length of employment, shall have his or her final average salary calculated using salaries adjusted in the manner established in this section.

(1) The member shall receive one (1) additional day of salary for retirement calculation purposes at the member’s base daily rate of pay for each day added to the member’s annual contract in excess of the member’s contracted days from the last immediately prior year round.

(2) The base daily rate of pay [that may be] used as additional salary credit shall not include compensation:

(a) For extra duties worked beyond the member’s primary job duties for which the member receives most of his or her compensation;

(b) That exceeds the limitations established by [of] KRS 161.220(9)(b);

(c) That is not "annual compensation" as defined by [under] KRS 161.220(10); or

(d) That is otherwise excluded from use in retirement calculations pursuant to KRS 161.220 through 161.716.

(3) The additional days shall be worked days in order to have the additional salary included for retirement calculation purposes.

Dr. TOM SHELTON, Chairperson
APPROVED BY AGENCY: September 17, 2012
FILED WITH LRC: November 15, 2012 at 8 a.m.
CONTACT PERSON: Robert B. Barnes, Deputy Executive Secretary of Operations and General Counsel, Kentucky Teachers’ Retirement System, 479 Versailles Road, Frankfort, Kentucky 40601, phone (502) 848-8508, fax (502) 573-0199.

Dr. TOM SHELTON, Chairperson
APPROVED BY AGENCY: September 17, 2012
FILED WITH LRC: November 15, 2012 at 8 a.m.
CONTACT PERSON: Robert B. Barnes, Deputy Executive Secretary of Operations and General Counsel, Kentucky Teachers’ Retirement System, 479 Versailles Road, Frankfort, Kentucky 40601, phone (502) 848-8508, fax (502) 573-0199.
FINANCE AND ADMINISTRATION CABINET
Department of Revenue
Office of Property Valuation
(As Amended at ARRS, January 7, 2013)

103 KAR 5:220. Installment payment plan guidelines for third party purchasers of certificates of delinquency.

RELATES TO: KRS 134.125, 134.126, 134.128, 134.129, 134.452, 134.490(5)(b)[134.390(5)(b)]

STATUTORY AUTHORITY: KRS 134.490(5)(b)[134.490(5)(b)]

NECESSITY, FUNCTION, AND CONFORMITY: KRS 134.490(5)(b) authorizes the Department of Revenue to promulgate Administrative Regulations to establish a process for an installment method of payment for the redemption of certificates of delinquency by a delinquent taxpayer. This section establishes the process by which third party purchasers shall grant installment payments and establishes the fee associated with this service.

Section 1. Definitions. (1) "Base amount" means the amount paid by a third-party purchaser for a certificate of delinquency.

(2) "Certificate of delinquency" is defined as follows:

(a) A statement that a payment plan is available upon written request from the property owner;

(b) The mailing address and the physical address where a request may be delivered. An electronic address may also be provided at the option of the third-party purchaser to accept requests in an electronic format;

(c) The date the certificate of delinquency was purchased by the third-party purchaser as provided in KRS 134.128, or paid and assigned as provided in KRS 134.126(8); and

(3) "Default" means:

(a) The failure to pay on or within fifteen (15) days of a payment due date under a payment plan document; or

(b) Commencement of any legal action by a person other than the third-party purchaser affecting the title or requiring the sale of the subject property.

(4) "Department" means the Department is defined by KRS 134.010(5)(b)(134.010(5)) means the Department of Revenue;

(5) "Optional certificate" means a certificate of delinquency that is not a qualifying certificate.

(6) "Payment plan" means a monthly installment plan.

(7) "Payment plan document" means the agreement between the property owner and the third-party purchaser detailing the terms of a payment plan.

(8) "Person" means any individual, corporation, business trust, estate, trust, partnership, limited liability entity, association, organization, joint venture, government, or any subdivision, agency or instrumentality thereof, or any other legal or commercial entity.

(9) "Processing fee" means a fee that may be imposed by a third-party purchaser for administering a payment plan, as provided in KRS 134.490(5)(c). [The processing fee shall not exceed eight dollars per month during the term of the payment plan]

(10) "Property owner" means the person as defined in KRS 134.010(14), or any other owners of real property on which an outstanding certificate of delinquency is held by a third-party purchaser.

(11) "Qualifying certificate" means a certificate of delinquency purchased after June 1, 2012 by a third-party purchaser required to register with the department under KRS 134.129.

(12) "Subject property" means the property against which the lien relates.

(13) "Third-party purchaser" is defined by KRS 134.010(16)[134.010(16)] means a "third-party purchaser" as defined in KRS 134.010. Third-party purchaser as used in this administrative regulation also includes any assignee of a certificate of delinquency.

Section 2. Notice of Payment Plan Availability. (1) For purposes of this administrative regulation, the term "third-party purchaser" shall also include any assignee of a certificate of delinquency.

(2) Any third-party purchaser who owns a qualifying certificate shall provide notice of the availability of a payment plan to the property owner as required by KRS 134.490(3)(d)5, unless the conditions established by Section 7 of this administrative regulation apply. The notice shall include, at a minimum, the following information:

(a) A statement that a payment plan is available upon written request from the property owner;

(b) The mailing address and the physical address where a request may be delivered. An electronic address may also be provided at the option of the third-party purchaser to accept requests in an electronic format;

(c) The date the certificate of delinquency was purchased by the third-party purchaser as provided in KRS 134.128, or paid and assigned as provided in KRS 134.126(8); and

(d) A statement that the option to request a payment plan shall expire unless a written request for a payment plan is received by the third-party purchaser within twelve (12) months of the date the certificate of delinquency was purchased by the third-party purchaser.

Section 3. Submission and Review of Payment Plan Requests. (1) Any property owner with property subject to a qualifying certificate may submit a written request for a payment plan to the third-party purchaser holding the qualifying certificate within twelve (12) months of the date the certificate of delinquency was purchased by the third-party purchaser as provided in KRS 134.128; or paid and assigned as provided in KRS 134.126(8).

(2) Upon receipt of a payment plan request, the third-party purchaser shall review the request, and if the request is timely and none of the conditions listed under Section 7 of this administrative regulation apply, the third-party purchaser shall prepare and deliver payment plan documents to the property owner in accordance with the provisions of this administrative regulation.

(3) Beginning with receipt of a request for a payment plan, and during the term of any payment plan, the third-party purchaser shall not assign the certificate of delinquency or undertake any enforcement remedies available under the law for collection of the amount due on a certificate of delinquency. However, this provision shall not preclude a third-party purchaser from engaging in legal proceedings to protect its interest in property subject to its lien and to charge reasonable legal and administrative fees in accordance with KRS 134.452(3). If the request for a payment plan is rejected because it is not timely or one of the conditions listed in Section 7 of this administrative regulation applies, or if the property owner defaults, the third-party purchaser may pursue any legal remedies available to the third-party purchaser under the law for collection of the amount due.

(4) A third-party purchaser may accept a request for a payment plan that is not timely filed. A payment plan entered into under this subsection shall be governed by the provisions of this administrative regulation.

Section 4. Payment Plan Requirements and Terms. (1) The payment plan shall provide for equal monthly installments, except the amount due in the final month may be adjusted to reconcile the total amount paid with the total amount due. The payment plan shall be offered for a minimum of twelve (12) months, unless the property owner requests a shorter term.

(2) The terms and conditions of the payment plan shall be established by a payment plan document, which shall be signed by the property owner and the third-party purchaser. The third-party purchaser shall provide a copy of the executed document to the property owner. The payment plan document shall be effective upon receipt by the third-party purchaser.

(3) The payment plan document shall include the following:

(a) A description of the subject property and the tax bill covered by the certificate of delinquency;

(b) The base amount due when the final payment is due;

(c) The total amount of pre-litigation attorney fees and administrative fees incurred and accrued as provided in KRS 134.452.
and due when the payment plan document is executed;

(2) The amount of interest accrued when the payment plan document is executed, calculated as provided in KRS 134.452 and 134.125;

(e) The term of the payment plan and number of monthly payments;

(f) The amount of interest that will accrue over the term of the payment plan, assuming payments are made according to the payment plan schedule;

(g) The amount of the monthly processing fee imposed;

(h) The monthly payment amount due, as determined as provided in Section 5 of this administrative regulation;

(i) The date the monthly payment amount is due;

(j) A statement that the taxpayer shall be in default for the failure to pay within fifteen (15) days of a payment due date, as provided in Section 1(3)(a) of this administrative regulation, which would allow the third-party purchaser, at his discretion, to discontinue accepting payments in accordance with the plan and pursue any other legal remedy available to collect the debt (payment plan will be considered in default and may be terminated if payment is not received within fifteen (15) business days of the due date);

(k) Acceptable methods of payment;

(l) The mailing address and delivery address where payments are to be made, if the payments are to be mailed; and

(m) Any other terms and conditions mutually agreed upon by the property owner and third-party purchaser.

(n) A statement that the third-party purchaser shall notify the taxpayer within seven (7) business days by certified mail if the certificate of delinquency related to the payment plan is assigned. The notification shall include the name, address, and telephone number of the assignee.

(3) The third-party purchaser may limit the method of payment accepted to those methods reasonably determined to ensure payment. Except as provided that a third-party purchaser shall accept certified checks, cashier’s checks, and cash in payment. A third-party purchaser may, at the discretion of the third-party purchaser, also accept ACH transfers, wire transfers, credit card, personal check, or other means of payment.

4. If multiple certificates of delinquency are included under the payment plan, all payments received will be applied as follows:

(a) First, to the payment of unpaid processing fees of the period prior to default, including the processing fee due in the month the default occurred;

(b) Second, to outstanding interest due;

(c) Third, to outstanding fees charged as set forth in KRS 134.452 [pre-litigation attorney fees and administrative fees imposed, as permitted under KRS 134.452 and included as part of the payment plan document]; and

(d) Fourth, to reduce the base amount due.

Section 7. Conditions Under Which A Payment Plan Is Not Required. A third-party purchaser shall not be required to offer a payment plan to a property owner under the following circumstances:

(1) The property owner has previously defaulted on a payment plan with that third-party purchaser; or

(2) An agreed judgment, agreed order, or other court order is in place that addresses the payment of the underlying tax claim or claims covered by a certificate of delinquency.

Section 8. Optional Payment Plans. (1) A third-party purchaser who is not required to register with the department under KRS 134.129, or who holds optional certificates of delinquency may offer payment plans to property owners under the same terms, conditions, and requirements established by this administrative regulation.

(2) Any payment plan agreement between a third-party purchaser and a property owner in existence on the effective date of this administrative regulation shall remain in effect according to the terms of the existing agreement. The third-party purchaser shall not impose the processing fee authorized by KRS 134.490(5)(c) as part of an installment payment plan agreement relating to a certificate or certificates of delinquency purchased on or before June 1, 2012 [this regulation].

THOMAS B. MILLER, Commissioner
APPROVED BY AGENCY: August 31, 2012
FILED WITH LRC: September 4, 2012 at 3 p.m.
CONTACT PERSON: DeVon Hankins, Policy Advisor, Office of General Counsel, Finance and Administration Cabinet, 392 Capitol Annex, Frankfort, Kentucky 40601, phone (502) 564-6660, fax (502) 564-9875.
VOLUME 39, NUMBER 8 – FEBRUARY 1, 2013

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(As Amended at ARRS, January 7, 2013)

201 KAR 9:001. Definitions for terms used in KRS 218A.172.[201 KAR Chapter 9][terms used in KRS 218A.172]

RELATES TO: KRS 218A.172, 311.530-311.620, 311.990
STATUTORY AUTHORITY: KRS 311.565(1)(a)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.565(1)(a) authorizes the board to promulgate administrative regulations to regulate the conduct of its licensees. This administrative regulation establishes the definitions for terms used in KRS 218A.172.[201 KAR Chapter 9][terms used in KRS 218A.172].

Section 1. Definitions. (1) “Administering a controlled substance or anesthesia immediately prior to or during surgery” means:
(a) Administering a controlled substance or anesthesia immediately prior to surgery;
(b) Administering a controlled substance or anesthesia during surgery; or
(c) Dispensing a controlled substance for up to forty-eight (48) hours, or prescribing a controlled substance for up to seven (7) days, immediately following surgery if the controlled substance is prescribed for the medically appropriate treatment of pain resulting from the surgery, whether the surgery or procedure is performed on an inpatient, outpatient or office basis.

(2) “Emergency situation” means any situation in which the prescriber reasonably determines that immediate medical treatment is necessary to appropriately and adequately address the individual’s presenting medical condition, including those identified in KRS 218A.172(4)(b).

(3) “Health facility” is defined by KRS 216B.015(13).

(4) “Initial prescribing” means the first time that a practitioner prescribes a Schedule II controlled substance or a Schedule III controlled substance with hydrocodone to treat a specific medical condition, and related symptoms, for a particular patient, and does not include:
(a) A change in dose of that substance; or
(b) The subsequent prescribing of any other Schedule II controlled substance or Schedule III controlled substance containing hydrocodone by that practitioner, by another practitioner in the same integrated group practice as the practitioner, or by another practitioner providing coverage to the initially prescribing practitioner, who also has lawful access to the patient’s medical record for the medically appropriate treatment of that same medical condition, and related symptoms.

(5) “Patient when functioning within the scope of a hospice program” means any patient receiving end of life care or any patient suffering from cancer or from the treatment of cancer, in any setting.

(6) “Prescribe” means to issue a written, electronic, or oral order for a drug or medicine, or combination or mixture of drugs or medicines, or proprietary preparation, that:
(a) Is signed, given, or authorized by a licensee; and
(b) Does not include the direct administration of the drug or medicine to a patient in a licensed health facility.

(7)(6) “Query the electronic monitoring system” means obtaining and reviewing KASPER data:
(a) For the twelve (12) month period immediately preceding the patient encounter for initial prescribing; or
(b) For the period since the most recent KASPER review for all prescribing that requires a subsequent review as required by KRS 218A.202(2).

(8)(7) “Surgery” means an operative procedure, invasive procedure, delivery, or other procedure requiring conscious sedation for completion. [The following terms used in KRS 218A.172 are defined in the following manner:]

(1) “Query the electronic monitoring system” means, in the setting of a licensed hospital, long term care facility or surgical center:
(a) The admitting physician, admitting the patient for observation, inpatient or outpatient purposes, obtaining and reviewing the KASPER immediately prior or promptly after the patient’s admission to the hospital;
(b) The admitting physician reviewing the KASPER report into the patient chart for use by all practitioners in the hospital for that patient during that specific admission;
(c) Each practitioner reviewing the KASPER report in the patient chart before prescribing controlled substances during the course of that specific admission; and
(d) The discharging practitioner reviewing the KASPER report in the patient chart before prescribing controlled substances for up to seventy-two (72) hours, immediately following surgery if the controlled substance is prescribed or the forty-eight (48) hour period immediately following surgery if the controlled substance is dispensed for the treatment of pain resulting from the surgery, whether the surgery is performed on an inpatient or outpatient basis.

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: November 14, 2012
FILED WITH LRC: November 15, 2012 at 11 a.m.
CONTACT PERSON: C. Lloyd Vest II, General Counsel, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, phone (502) 429-7150, fax (502) 429-7118.

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(As Amended at ARRS, January 7, 2013)

201 KAR 9:081. Disciplinary proceedings.

RELATES TO: 218A.205, KRS 311.530-311.620, 311.990
STATUTORY AUTHORITY: KRS 218A.205(3)(c), (d), (e); 311.565(1)(a)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.565(1)(a) authorizes the board to promulgate administrative regulations to regulate the conduct of licensees. KRS 311.595 and 311.597 authorize disciplinary action against licensees for specified offenses. KRS 218A.205(3)(c), (d), and (e) requires the board to promulgate an administrative regulation establishing procedures for disciplinary action against a licensee that empowers the State Board of Medical Licensure to exercise all the administrative functions of the state in the prevention of empiricism and in the administrative regulation of the practice of medicine and osteopathic medicine and authorizes the board to establish requirements and standards relating thereto. [The purpose of this administrative regulation is to set forth the procedures to be followed in handling formal and informal disciplinary proceedings before the board or before any committee to the board, to conduct [such that] the proceedings will be conducted] with due regard for the rights and privileges of all affected parties.

Section 1. Definitions. (1) “Act” means the Kentucky Medical and Osteopathic Practice Act, KRS 311.550 to 311.620.

(2) “Board” is defined by KRS 311.550(1).

(3) “Charge” is defined by KRS 311.550(14).

(4) “Complaint” is defined by KRS 311.550(15).

(5) “Executive director” is defined by KRS 311.550(4).

(6) “General counsel” is defined by KRS 311.550(2).

(7) “Grievance” is defined by KRS 311.550(13).

(8) “Hearing officer” means the person designated and given authority by the board to preside over all proceedings pursuant to the issuance of any complaint or show cause order.

(9) “Relating to a controlled substance” means any conviction or plea to a criminal charge, regardless of adjudication or the title of the offense named in the plea or judgment of conviction, that is determined from all available facts to have been based upon or resulted from, in whole or part, an allegation of conduct involving the improper, inappropriate, or illeg-
al use, possession, transfer, prescribing, or dispensing of a controlled substance.

(10) “Show cause order” means an order issued pursuant to KRS 311.572. “Executive director” means the executive director of the board or any assistant executive director appointed by the board.

(2) “General counsel” means the general counsel of the board or any assistant general counsel appointed by the board.

(3) “Board” means the Kentucky Board of Medical Licensure or its inquiry or hearing panels.

(4) “Grievance” means any allegation in whatever form alleging misconduct by a physician.

(5) “Charge” means a specific allegation contained in any document issued by the board or its inquiry or hearing panels alleging a violation of a specified provision of the Kentucky Medical and Osteopathic Practice Act.

(6) “Complaint” means a formal administrative pleading authorized by the inquiry panel that sets forth charges against a physician and commences a formal disciplinary proceeding.

(7) “Show cause order” means an order directing the named physician to show cause why the board should or should not take a specified action based on specified information which the order alleges to be true.

(8) “Hearing officer” means the person designated and given authority by the board to preside over all proceedings pursuant to the issuance of any complaint or show cause order.

(9) “Informal proceedings” means proceedings instituted at any stage of the disciplinary process with the intent of reaching an informal dispensation of any matter without further recourse to formal disciplinary procedures.

(10) “Act” means the Kentucky Medical and Osteopathic Practice Act.

Section 2. Reception of Grievances; Investigations. (1) (a) A grievance may be submitted by any individual, organization, or entity.

(b) The board shall provide a copy of the Information on Filling a Grievance, the Consumer’s Guide to the KBML, the Grievance Form, and the Waiver of Privilege Agreement to Release Records to a party who wants to register a grievance against a physician.

2. Each grievance shall be filed on the Grievance Form; and

a. Include the name and address of the party filing the grievance;

b. Be filed anonymously, subject to paragraph (d) of this subsection;

c. Retain a written form upon which grievances may be made and any party submitting a grievance may be required to complete the form and required to include the party’s name and address unless the grievance is submitted anonymously;

d. Be signed by providing a written memorandum to the executive director.

(d) If the board receives an anonymous grievance, an investigation shall only be conducted if the grievance is accompanied by sufficient corroboration as would allow the board to believe, based upon a totality of the circumstances, that a reasonable probability exists that the grievance is meritorious. [and may also be required to give their affidavit acknowledging the truth and veracity to the best of their knowledge and belief of the information contained in the grievance.)

(2) The board shall initiate each investigation pertaining to prescribing or dispensing of a controlled substance within seventy-two (72) hours of the date of receipt of the grievance.

(b) Except as provided by subsection (1)(d) of this section, each grievance shall be investigated as necessary and as promptly as possible, and presented to the inquiry panel for review.

(c) An investigation pertaining to prescribing or dispensing of a controlled substance shall be presented to the inquiry panel within 120 days of the date of receipt of the grievance unless the circumstances of a particular grievance make it impossible to timely present the grievance to the inquiry panel.

(d1) The executive director may hold an investigation pertaining to prescribing or dispensing of a controlled substance in abeyance for a reasonable period of time in order to permit a law enforcement agency to perform or complete essential investigative tasks, following a request by the requesting law enforcement agency.

2. [If in each instance when] an investigation pertaining to prescribing or dispensing of a controlled substance is not presented to the inquiry panel within 120 days of the date of receipt of the grievance, the investigative report shall[will] plainly state the circumstances of that particular grievance or investigation that made timely presentation to the inquiry panel impossible.

(c) The inquiry panel of executive director shall have the authority to direct any investigation and shall possess any and all powers necessary to the board in regard to investigations as provided by KRS 311.591 and 311.605.

(d) The inquiry panel shall further be empowered to request the attendance of any person at any meeting of the inquiry panel in regard to the investigation of any grievance or consideration of any disciplinary matter.

(e) The failure, without good cause, of any physician licensed to practice medicine or osteopathy by the board to appear before the inquiry panel when requested shall be considered unprofessional conduct in violation of KRS 311.595(9).

(3) The inquiry panel shall be empowered to request compliance with the reporting requirements of KRS 311.605 of the inquiry panel.

(f) The inquiry panel may pursue an investigation on its own initiative, in regard to an act of noncompliance or any other perceived violation of the Act.

Section 3. Reports and Recommendations; Petitions. (1) If, in the opinion of the inquiry panel determines that a grievance warrants the issuance of a complaint against a physician, the inquiry panel shall cause a complaint to be prepared.

(2) If the panel chair determines that a grievance warrants the issuance of a complaint against a physician and circumstances do not allow the timely presentation of the grievance to the inquiry panel, the panel chair shall cause a complaint to be prepared.

(3) If, in the opinion of the executive director, the inquiry panel determines that a disciplinary matter warrants the issuance of a show cause order against a physician, the executive director or the inquiry panel shall cause a proposed order to be prepared.

(4) The board may, on its own initiative, may issue a show cause order against a physician in regard to any application for licensure, obtaining, retaining, or reobtaining licensure.

If in this subsection shall be construed to limit the board’s power to deny a license to any applicant without a prior hearing upon a finding that the applicant has violated any provision of the Act.

Section 4. Complaints. (1) The complaint issued by an inquiry panel shall;

1. Be signed and dated;

2. The complaint shall be styled in regard to the matter of the license to practice in the Commonwealth of Kentucky held by the named physician and designated with an appropriate case number; and

3. The complaint shall Set forth:

(a) The board’s jurisdiction in regard to the subject matter of the complaint; and

(b) A further set forth, in numerical paragraphs, sufficient information to apprise the named physician of the general nature of the charges.

Section 5. Show Cause Orders. (1) The show cause order shall;

1. Be signed and dated by an officer of the board;

2. And shall be dated. The show cause order shall be
styled in regard to the license, application for license, or application for renewal, registration, or reregistration of a license to practice in the Commonwealth of Kentucky held by or submitted by the named physician, appropriately, and if [shall be] designated with an appropriate order number.

(3) The show cause order shall be served.

(4) The show cause order shall set forth:

(a) The board's jurisdiction in regard to the subject matter of the order; and

(b) [shall further set forth.] In numerical paragraphs, the information which the board accepts to be true and the statutory basis for the board's finding that grounds exist for the discipline of the named physician's license; and

Section 6. Orders to Respond. Upon issuance of a complaint, the inquiry panel shall notify [issue an order directing] the named physician to receive actual notice after execution of a show cause order and [shall further set forth] that any orders issued pursuant to such motions shall not be considered a part of the record.

Section 7. Notice and Service of Process. Each notice shall be issued as required by KRS 13B.020. (4) Any notice required by the Act or this administrative regulation shall be in writing, dated and signed by the appropriate person.

(2) Service of notice and other process shall be made by hand-delivery or by certified mail to the physician's last known address of which the board has record or by such service on the named physician's attorney of record. Failure of the named physician to receive actual notice after execution of the prescribed service shall not prejudice the board from pursuing proceedings that result in the denial or discipline of the named physician's license. (Section 9. Hearings Pursuant to Order Temporarily Suspending, Limiting or Restricting a License. (1) A physician whose license has been temporarily suspended, limited or restricted shall, upon written request, be accorded hearing on the board's order.

(2) At the hearing on the order of temporary discipline, the hearing officer may detain any motion timely submitted in regard to any matter concerning the disciplinary case, provided, however, that any orders issued pursuant to such motions shall not be considered appealable.

(3) Either party to the hearing on the order of temporary discipline may petition the hearing panel to review the order of the hearing officer pursuant to the issuance of a complaint or show cause order move the hearing officer to order that discovery from the other party be allowed.

(4) The provisions of KRS Chapter 13B shall govern the conduct of each proceeding. Form of pleadings, service. Pleadings, in any form, may be accepted to the discovery of all issues, documents and matters in controversy. Any order for the taking of evidence shall be served on all parties and may require the submission of briefs in regard to any issue. The hearing officer may allow opening and closing statements by either party, or other offers of proof or trial that will allow the orderly and expeditious conduct of the proceedings.

Section 8. Proceedings Pursuant to the Issuance of a Complaint or Show Cause Order. (1) Appointment of hearing officer. The board shall appoint a hearing officer in accordance with KRS 13B.030 and 13B.040 who is empowered to preside at any and all proceedings. The board may appoint a special prosecuting attorney in regard to any disciplinary proceeding, unless the board appoints a special prosecuting attorney, provided, however, that the board may appoint special prosecuting attorneys in its discretion.

(2) Appointment of the prosecuting attorney. The board's general counsel or assistant general counsel shall act as the prosecuting attorney in regard to any disciplinary proceeding, unless the board appoints a special prosecuting attorney in its discretion. The prosecuting attorney shall not participate in any deliberations of the board pursuant to the issuance of a complaint, show cause order, or order of temporary discipline.

(3) Appointment of advisory counsel. The board may appoint a representative of the Attorney General's office, the board's general counsel or any other attorney or advisory counsel to the board in regard to any deliberations of the board pursuant to the issuance of a complaint, show cause order, or order of temporary discipline.

(4) The provisions of KRS Chapter 13B shall govern the conduct of each proceeding. Form of pleadings, service. Pleadings may be in any form provided that all pleadings must be served and signed by the persons to whom the pleadings are directed, and all pleadings must be signed and dated by the attorney representing the person opposing the petitioner.

(5) Prehearing conferences. Upon motion of either party or upon his or her own initiative, the hearing officer may order that a prehearing conference be held. The prehearing conference may be the forum for consideration of any matter prior to the hearing officer's determination.

(6) Discovery. Either party may at any time after the issuance of a complaint or show cause order move the hearing officer to order that discovery from the other party be allowed by any of the following methods:

(a) Oral deposition, provided, however, that either party shall have the right to move the hearing officer to order that the deposition be entered into the record in lieu of further testimony by the witness;

(b) Request for a more definite statement;

(c) Request for production of names of witnesses, documents and other demonstrative evidence; and

(d) Request for a list of all pleadings each of which is considered evidence of the testimony expected to be given by any expert witness.

The hearing officer may limit or allow discovery of any matter relevant to the issues and may issue protective orders as necessary.

(2) Hearings. Hearings shall proceed in accordance with the rules of examination applicable in courts of law in the Commonwealth. The rules of evidence applicable in courts of law in the Commonwealth shall apply, provided, however, that hearsay evidence shall be admissible unless irrelevant or grossly prejudicial. The order and burden of proof shall be established by the hearing officer, provided, however, that the burden of proof shall be upon the charged physician in any hearing on the charges contained in a show cause order. The hearing officer shall rule upon any motions or objections and may require the submission of briefs in regard to any issue. The hearing officer may allow opening and closing statements by either party, or other offers of evidence or trial that will allow the orderly and expeditious conduct of the proceedings.

(5) Record. The hearing officer shall be charged with the responsibility of compiling a written record of the proceedings which shall contain all evidence introduced at the hearing and all pleadings, motions, objections, responses, rulings and other legal documents which the hearing officer deems properly part of the record.

(9) Presentation of record, hearing officer's proposed find-
ings, conclusions and recommendations. The hearing officer shall present the record, his or her proposed findings of fact, conclusions of law and recommendations to the executive director for deliberation by the hearing panel. The hearing officer shall serve a copy of the record, the conclusions and recommendations on all parties at least twenty (20) days prior to the date set for the hearing panel’s final determination. All parties shall have the right to file exceptions to the hearing officer’s findings, conclusions and recommendations ten (10) days prior to the date set for the hearing panel’s final determination.

(10) Briefs. Any party to the proceeding may move the hearing officer to allow briefs to be filed with the hearing panel prior to the hearing panel’s final determination. The hearing officer may grant the motion and establish a briefing schedule but only if the hearing officer believes that such a procedure would substantially aid the hearing panel in its deliberations. Briefs shall not exceed five (5) pages in length unless otherwise ordered by the hearing panel. The hearing panel may, on its own initiative, order that briefs be submitted.

(11) Oral argument. Any party to the proceeding may move the hearing panel to allow oral argument prior to the hearing panel’s final determination. The hearing panel may order oral arguments on its own initiative.

(12) Board’s findings of fact, conclusions of law and final order. After the conclusion of its deliberations the hearing panel may adopt the hearing officer’s proposed findings, conclusions and recommendations of action in whole or in part or may reject them totally and prepare its own. The hearing panel shall enter a final order dated and signed by an officer of the hearing panel stating its ultimate determination. Prior to, during or subsequent to any deliberations the hearing panel may request the matter to the hearing officer for further proceedings as directed.

Section 9. Meetings of the Board and Panels. (1) The full membership of the Board shall meet quarterly each calendar year, in the months of March, June, September, and December. At such meetings, the board will make licensing decisions regarding initial applications for licensure, make decisions regarding renewal applications, enter into contractual relationships, and address issues of general policy or interpretation of statute.

(2) The members of Inquiry Panel A shall meet bimonthly, each calendar year, in the months of February, April, June, August, October and December. At such meetings, Inquiry Panel A will finally resolve cases in which a hearing has been conducted or a negotiated settlement tendered, will determine whether to grant requests to modify or terminate previously accepted negotiated settlements, will determine appropriate action upon recently completed investigations, and will make licensing decisions regarding renewal applications. At its June and December meetings, upon conclusion of the meeting of the full Board, Inquiry Panel A will take appropriate action upon recently completed investigations of prescribing or dispensing of controlled substances and other matters that require immediate attention.

(3) The members of Inquiry Panel B shall meet bimonthly each calendar year, in the months of January, March, May, July, September, and November. At the January, May, July and November meetings, Inquiry Panel B will finally resolve cases in which a hearing has been conducted or a negotiated settlement tendered, will determine whether to grant requests to modify or terminate previously accepted negotiated settlements, will determine appropriate action upon recently completed investigations, and will make licensing decisions regarding renewal applications. At its January, May, July and November meetings, which coincide with the meeting of the full Board, Inquiry Panel B will take appropriate action upon recently completed investigations of prescribing or dispensing of controlled substances and other matters that require immediate attention.

Section 10. Definitions. “A conviction relating to controlled substances” shall include any conviction or plea to criminal charges, regardless of adjudication, that is based upon or resulted from, in whole or in part, allegations of conduct involving the improper, inappropriate or illegal use, possession, transfer, prescribing or dispensing of controlled substances. The underlying facts of the offense, rather than the title of the offense named in the plea or judgment of conviction, will be determinative of whether the conviction or plea was “relating to controlled substances.”

Section 11. Mandatory Reporting; Mandatory Disciplinary Sanctions: Emergency Action: Expedited Proceedings. (1)(a) Any applicant for initial licensing to practice medicine or osteopathy within the Commonwealth of Kentucky shall report upon the applicant’s initial application any criminal conviction of which the applicant has knowledge. The license shall provide a copy of the judgment of conviction or plea document entered into in any state, regardless of adjudication.

(b) Any applicant for initial licensing to practice medicine or osteopathy within the Commonwealth of Kentucky shall report upon the applicant’s initial application any disciplinary action taken or sanction imposed upon the applicant by any licensing authority in any state, including surrendering or placing the applicant’s license in an inactive or retired status to resolve a pending investigation by the licensing authority.

(c) Any applicant for initial licensing to practice medicine or osteopathy within the Commonwealth of Kentucky shall report upon the applicant’s initial application if the applicant has knowledge of any other state for possible violations of the licensing or regulatory statutes of that state.

(d) Every person licensed to practice medicine or osteopathy within the Commonwealth of Kentucky shall report to the board any criminal conviction or plea of guilt, no contest, or Alford plea to any criminal charges, regardless of adjudication, within ten (10) days of the entry of judgment of conviction or the entry of the plea, entered into in any state. As part of this reporting, the licensee shall provide a copy of the judgment of conviction or plea document entered into in any state.

(e) Every person licensed to practice medicine or osteopathy within the Commonwealth of Kentucky shall report to the board within ten (10) days of receipt, notice of any disciplinary action taken or sanction imposed upon the person’s license in any state, including surrendering or placing the person’s license in an inactive or retired status to resolve a pending investigation. As part of this reporting requirement, the licensee shall provide a copy of the order issued by or entered into with the other licensing board.

(f) Failure to report a criminal conviction or plea, or action taken by another licensing board, as required of an applicant by paragraphs (a) through (c) of this subsection, shall constitute a violation of KRS 311.595(9) and (12).

2. Upon a finding by the board that the applicant committed a such violation, the appropriate panel:
   a. Shall impose a fine of $5,000 and the appropriate sanction mandated by subsection (2), (3), or (4) of this section; and
   b. [Administrative regulation. In addition to these minimum mandatory sanctions, the panel] May impose any additional sanction authorized by KRS 311.595, including denial of the application or revocation of the license previously issued based upon the incomplete information.

(g) Failure to report a criminal conviction or plea, or action taken by another licensing board, as required of a licensee by paragraphs (d) and (e) of this subsection, shall constitute a violation of KRS 311.595(9) and (12).

2. Upon a finding by the board that the licensee committed a such violation, the appropriate panel:
   a. Shall impose a fine of $5,000 and the appropriate sanction mandated by subsection (2), (3), or (4) of this section; and
   b. [Administrative regulation. In addition to these minimum mandatory sanctions, the panel] May impose any additional sanction authorized by KRS 311.595 based upon all of the informa-
tion available to the panel at the time of action.

(2)(a) If an initial applicant reports being [that they are] the subject of a pending criminal investigation or of a pending investigation by a state licensing authority, the board shall defer any action upon that initial application until it has received official notice that the criminal or state licensing investigation has been completed and official notice of what action was taken as a result of the investigation.

(b) If an initial applicant has been convicted of a felony offense or entered a plea of guilt, an Alford plea, or a plea of no contest to any felony charge relating to a controlled substance(s), regardless of adjudication, in any state, the board shall [may] exercise its normal discretion to grant or deny the application based upon all available facts.

2. If the board decides to [should] grant a license to the [such an] initial applicant, the board:

a. Shall, at a minimum, permanently bar the applicant from prescribing or dispensing controlled substances as an express condition of granting the license.

b. [If the board grants the license subject to a permanent ban, it] May impose other conditions in addition to that permanent ban as express conditions of granting the license.

c. If a licensee has been convicted of or entered a plea of guilt, an Alford plea, or a plea of no contest to any felony offense relating to a controlled substance(s), regardless of adjudication, in any state, the board shall [may] exercise its normal discretion to grant or deny the application based upon all available information.

1. a. Shall, at a minimum, permanently bar the licensee from prescribing or dispensing controlled substances as a disciplinary sanction; and

b. [In lieu of this minimum sanction, the panel may] revoke the license based upon the facts available to the panel at the time of action.

(3)(a) If an initial applicant has been convicted of a misdemeanor offense relating to a controlled substance(s) or entered a plea of guilt, an Alford plea, or plea of no contest to a misdemeanor charge relating to a controlled substance(s), regardless of adjudication, in any state, the board shall [may] exercise its normal discretion to grant or deny the application based upon all available information.

2. If the board decides to [should] grant the application, the board:

a. Shall, at a minimum, ban the applicant from prescribing or dispensing controlled substances for a period of two (2) to five (5) years as an express condition of granting the license; and

b. [In lieu of the ban as a condition of granting the license, the board may] impose other conditions in addition to that ban as express conditions of granting the license.

(b) If a licensee has been convicted of or entered a plea of guilt, an Alford plea, or a plea of no contest to a misdemeanor offense relating to prescribing or dispensing a controlled substance(s), regardless of adjudication in any state, the board shall [may] exercise its normal discretion to grant or deny the application based upon all available information.

1. a. Shall, at a minimum, ban the licensee from prescribing or dispensing controlled substances for a period of two (2) to five (5) years as a disciplinary sanction; and

b. [In addition to this minimum sanction, the panel may] revoke the license based upon the facts available to the panel at the time of action.

(4)(a) If an initial applicant has surrendered the applicant's [their] professional license or placed that license into an inactive or retired status to resolve a pending licensing investigation, the board shall not grant a license to that initial applicant, unless the licensing authority of that state has subsequently reissued or reinstated the license.

2. If the licensing authority of the state has subsequently reissued or reinstated the license, the board shall [may] exercise its normal discretion in determining whether to grant or deny the application based upon the available facts.

(b) If an initial applicant has had a disciplinary action taken against or sanction imposed upon the applicant's license to practice medicine or osteopathy in any state, the board:

1. a. Shall, at a minimum, impose the same substantive sanction imposed by the other state as an express condition of granting the license; and

b. May [or may deny the application, or in addition to the minimum sanction] impose additional sanctions as an express condition of granting the license; or

2. Shall deny the application based upon the facts available at the time.

(c) If a licensee has had disciplinary action taken against or sanctions imposed upon the applicant’s [their] license to practice medicine or osteopathy in any state, the appropriate panel:

1. a. Shall, at a minimum, impose the same substantive sanctions as a disciplinary sanction against the applicant’s [their] Kentucky license; and

b. [In addition to this minimum sanction, the panel may] take any appropriate additional disciplinary action against the licensee.

2. Shall [or in lieu of the minimum sanction, the panel may] revoke the license based upon the facts available to the panel at the time of action.

(5)(a) Failure to report either a criminal conviction, an [er] plea, or a disciplinary sanction[s] by another licensing board, as required by this section, shall constitute [a violation of law which constitutes an immediate danger to the public health, safety, or welfare] [or purposes of KRS 311.592 and 138.125].

(b) If the board or one (1) of its panels learns that a licensee has suffered a qualifying criminal conviction or disciplinary sanction and has failed to report it as required by this section, the panel or its chair may immediately issue an emergency order appropriately suspending or restricting the licensee in accordance with this section.

(c) If [such] an emergency order is issued and an emergency hearing is conducted pursuant to KRS 138.125(3), the hearing officer shall not modify or amend the scope of the emergency order if there is substantial evidence to support the finding that the licensee failed to report a qualifying criminal conviction or disciplinary sanction as required by this section.

(d) If the only violation charged in a complaint against the licensee is a criminal conviction or disciplinary action described in this section, and the conviction or disciplinary action may be proved by accompanying official certification, the board shall take appropriate steps to expedite the resolution of that complaint.

(e) Following receipt of the licensee’s response to the complaint, board counsel shall promptly file a motion for summary disposition on the ground that no genuine issues of material fact are in dispute, pursuant to KRS 138.09(2).

(f) The licensees:

1. Shall not [be permitted to] re-litigate either the criminal conviction or disciplinary sanction, and

2. May offer as [the only available] defense [it] that the certification of the document is fraudulent.

(d)(1) If the licensees has admitted the occurrence of the criminal conviction or disciplinary action in the response, an [no] additional response shall not be given [as required or permitted] to the motion for summary disposition.

2. If the licensee has denied the occurrence of the criminal conviction or disciplinary sanction, and alleges that the certification is fraudulent, the licensee may file a response to the motion for summary disposition/resolution within twenty (20) days of receipt of the motion.

(g)(1) Once the assigned hearing officer determines that an [no] response was either not permitted or not filed within the allotted time or the hearing officer [is permitted to] has received the written response within the time allotted [or determines that a response was not filed within the allotted time], the hearing officer shall issue a ruling upon the motion as soon as possible but no later than thirty (30) days after the motion is submitted for decision.

2. If the hearing officer issues a recommended order, the recommended order shall be presented to the board’s hearing panel at its next meeting for resolution and imposition of the sanction required by this section.

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Section 10. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) “Information on Filing a Grievance”, January 2013;
(b) “Consumer’s Guide to the KBML”, January 2013;
(c) “Grievance Form”, January 2013; and
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, Monday through Friday, 8:00 a.m. to 4:30 p.m.

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: July 20, 2012
FILED WITH LRC: July 20, 2012 at 2 p.m.
CONTACT PERSON: C. Lloyd Vest II, General Counsel, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, phone (502) 429-7150, fax (502) 429-7118.

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(As Amended at ARRS, January 7, 2013)

RELATES TO: KRS 218A.205, 311.565, 311.571, 311.595(311.530-311.620, 311.990)
STATUTORY AUTHORITY: KRS 218A.205(3)(f), 311.595(1)(a), (k)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.565(1)(a), (k) authorize the board to promulgate administrative regulations establishing moral, physical, intellectual, educational, scientific, technical, and professional qualifications of applicants for licenses and permits that may be issued by the board. KRS 311.595 establishes the legal grounds for denial for an application for licensing. KRS 218A.205(3)(f) requires the board to promulgate an administrative regulation that establishes a procedure for continuous submission of all disciplinary and other reportable information to the National Practitioner Data Bank. KRS 218A.205(3)(g)2 requires the board to promulgate an administrative regulation establishing a procedure to submit a query on each applicant for licensure to the National Practitioner Data Bank to retrieve any relevant data on the applicant to regulate the conduct of its licensees. KRS 311.595(1)(k) authorizes the board to utilize the services and facilities of professional organizations, and procure and receive the assistance and recommendations of professional organizations in administering KRS 311.530 to 311.620. This administrative regulation establishes the requirements of obtaining information from and reporting information to the National Practitioner Data Bank.

Section 1. (1)(a) The board shall submit a query to obtain a report from the National Practitioner Data Bank,[which includes all available information,] on each applicant for initial licensing within the Commonwealth of Kentucky, to retrieve any relevant data on the applicant.
(b) The board shall not grant an initial license to practice medicine or osteopathy within the Commonwealth unless and until it has received and reviewed the National Practitioner Data Bank report for that applicant.
(2) The board shall promptly report each order issued by its panels, whether a final order or an agreed order, relating to a specific licensee to the National Practitioner Data Bank [in accordance with rules and regulations published by the United States Department of Health and Human Services, Health Resources and Services Administration].

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: July 20, 2012
FILED WITH LRC: July 20, 2012 at 2 p.m.
CONTACT PERSON: C. Lloyd Vest II, General Counsel, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, phone (502) 429-7150, fax (502) 429-7118.

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(As Amended at ARRS, January 7, 2013)

RELATES TO: KRS 218A.205, 311.565, 311.571, 311.595(311.530-311.620, 311.990, 218A.205)
STATUTORY AUTHORITY: KRS 218A.205(3)(g), 311.565(1)(b), (k), (l)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.565(1)(b) authorizes the board to promulgate administrative regulations establishing moral, physical, intellectual, educational scientific, technical, and professional qualifications of applicants for licenses and permits that may be issued by the board. KRS 311.595 establishes the legal grounds for denial for an application for licensing. KRS 311.565(1)(l) authorizes the board to require a criminal background investigation of all persons applying for licensure at the time of initial application by means of a fingerprint check by the Department of Kentucky State Police and Federal Bureau of Investigation. KRS 218A.205(3)(g) requires the board to promulgate an administrative regulation establishing a process for obtaining a national and state fingerprint-supported criminal record check for initial applicants. This administrative regulation establishes the requirement for criminal background checks for all new applicants.

Section 1. (1) The board shall obtain a fingerprint-supported criminal record check conducted[require a criminal background investigation, by means of a fingerprint check] by the Department of Kentucky State Police and Federal Bureau of Investigation, on each applicant[of all persons applying] for initial licensing to practice medicine or osteopathy within the Commonwealth of Kentucky.
(2) The board shall not grant an initial license to practice medicine or osteopathy within the Commonwealth until it has received and reviewed the criminal background investigations by both the Department of Kentucky State Police and the Federal Bureau of Investigation for that applicant.

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: July 20, 2012
FILED WITH LRC: July 20, 2012 at 2 p.m.
CONTACT PERSON: C. Lloyd Vest II, General Counsel, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, phone (502) 429-7150, fax (502) 429-7118.

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(As Amended at ARRS, January 7, 2013)

201 KAR 9:220. Restriction upon dispensing of Schedule II controlled substances and Schedule III controlled substances containing Hydrocodone.
RELATES TO: KRS 218A.205(3)(b), 311.595(9), (12), 311.597(311.530-311.620, 311.990)
STATUTORY AUTHORITY: KRS 218A.205(3)(b), 311.565(1)(a)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.565(1)(a) authorizes the board to promulgate administrative regulations to regulate the conduct of licensees. KRS 218A.205(3)(b) requires the board to promulgate an administrative regulation to prohibit a practitioner from dispensing greater than a forty-eight (48) hour supply of any Schedule II controlled substance or a Schedule III controlled substance containing...
Section 1. (1) No physician licensed in Kentucky shall not dispense an amount greater than a forty-eight (48) hour supply of any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a patient, unless the dispensing is done as part of a narcotic treatment program licensed by the Cabinet for Health and Family Services. This administrative regulation establishes that the time designated to maintain such registration contiguously during their licensure, as required by subsections (1) to (3) of this section shall constitute violations of KRS 311.595(9) and (12) and shall provide a basis for disciplinary action against the Kentucky license pursuant to KRS 311.595.

Section 2. (1) In order to lawfully prescribe or dispense a controlled substance within the Commonwealth of Kentucky, a licensee shall:

(a) [must] Hold a valid DEA permit to do so; and
(b) [must] Be registered with [the Cabinet for Health and Family Services] to use the KASPER system as required by KRS 218A.202.

(2) Prescribing or dispensing a controlled substance without a valid DEA permit or KASPER registration, as required by subsection (1) of this section, (2) Failure to be registered with the Cabinet for Health and Family Services to use the KASPER system at any time while the licensee holds a valid DEA permit to prescribe or dispense controlled substances to humans within the Commonwealth of Kentucky constitutes a violation of KRS 311.595(9) and (12) which constitutes an immediate danger to the public health, safety, or welfare, for the purposes of KRS 311.592 and 13B.125.

(3) (a) If the board receives documentation from the Cabinet for Health and Family Services that a licensee holds a valid DEA permit to prescribe or dispense controlled substances to humans within the Commonwealth of Kentucky, but is not currently registered with the cabinet to use the KASPER system as required by KRS 218A.202, the board shall:

(i) immediately send written notice, by certified mail, return receipt requested, to the physician that the physician is required to register with the Cabinet for Health and Family Services to use the KASPER system within seven (7) days of receipt of the written notice;

(b) At the end of the seven (7) day period, the board shall confirm with the Cabinet for Health and Family Services that the physician registered with the cabinet to use the KASPER system;

(c) If the physician failed to register with the cabinet for Health and Family Services to use the KASPER system within the seven (7) days following receipt of the written notice, the appropriate inquiry panel or its chair shall promptly issue an emergency order restricting that licensee from prescribing or dispensing controlled substances within the Commonwealth of Kentucky until such time as the licensee has registered with the cabinet to use the KASPER system.

(4) (a) An emergency order restricting a licensee from prescribing or dispensing controlled substances within the Commonwealth of Kentucky issued pursuant to subsection (3)(c) of this section requests an emergency hearing pursuant to subsection (3)(c) of this section requests an emergency hearing pursuant to KRS 13B.125(3), the hearing officer conducting the emergency hearing shall affirm the emergency order of restriction if presented with a written notification on cabinet letterhead stating that the affected licensee holds a valid DEA permit but is not registered with the cabinet to use the KASPER system as required by KRS 218A.202.

(5) If a licensee who is affected by an emergency order issued pursuant to subsection (3)(c) of this section requests an emergency hearing pursuant to KRS 13B.125(3), the hearing officer conducting the emergency hearing shall affirm the emergency order of restriction if presented with a written notification on cabinet letterhead stating that the affected licensee holds a valid DEA permit but is not registered with the cabinet to use the KASPER system as required by KRS 218A.202.

Section 2(3). If a licensee prescribes or dispenses a controlled substance within the Commonwealth of Kentucky during any period when the licensee is not registered with the cabinet to use the KASPER system, each instance of prescribing or dispensing shall constitute a violation of KRS 311.595(12) and (9), as illustrated by KRS 311.597(1)(b) and shall constitute a basis for disciplinary sanctions pursuant to KRS 311.595.

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: July 20, 2012
FILED WITH LRC: July 20, 2012 at 2 p.m.
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GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(As Amended at ARRS, January 7, 2013)

201 KAR 9:240. Emergency orders and hearings; appeals and other proceedings.

RELATES TO: KRS 218A.205, 311.565(1)(l), 311.592(1)[311.530-111.620, 311.990]

STATUTORY AUTHORITY: KRS 311.565(1)(a)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.565(1)(f)[(a)] authorizes the board to promulgate administrative regulations to promote the efficient and fair conduct of disciplinary proceedings [regulate the conducted of its licensees]. KRS 311.595 and 311.597 authorize disciplinary action against licensees for specified offenses. The purpose of this administrative regulation establishes[s] to set forth the procedure to be followed in handling emergency proceedings before the board.

Section 1. Authority to Issue Emergency Order; Timing. (1) An inquiry panel or the panel’s chair, acting on behalf of the inquiry panel, may issue an emergency order restricting or suspending a physician’s license to practice medicine or osteopathy within the Commonwealth of Kentucky in accordance with KRS 311.592 and 13B.125 whenever the inquiry panel or the panel’s chair has reasonable cause to believe that:

(a) The physician has violated one (1) or more terms of an agreed order entered into between the physician and one (1) of the board’s panels, or has violated one (1) or more terms of a disciplinary order issued by one (1) of the board’s hearing panels; or

(b) The physician’s practice constitutes a danger to the health, welfare and safety of his patients or the general public.

(2) An inquiry panel shall make this [will normally make such] determination following when it considers [a completed investigation pursuant to KRS 311.591(3) at a regularly scheduled meeting of the inquiry panel.

(3) (a) An inquiry panel’s chair may act on behalf of the inquiry panel and issue an emergency order restricting or suspending a physician’s license to practice medicine or osteopathy within the Commonwealth of Kentucky [when] the panel chair determines that a basis[ground] for an emergency order as established[delineated] in subsection (1) of this section exists and the circumstances of the specific case warrant emergency action prior to the next regularly scheduled meeting of the inquiry panel.

(3)(b) If an emergency hearing is scheduled prior to the next regularly scheduled meeting of the inquiry panel, the panel chair may [also] act on behalf of the inquiry panel and issue the complaint required to support the continuation of the emergency order.

(c) If [Whenever] the panel chair acts on behalf of the inquiry panel pursuant to paragraph (a) or (b) of this subsection, the panel chair shall report any action[such actions] to the inquiry panel at its next regularly scheduled meeting.

Section 2. Findings of Fact and Conclusions of Law. (1) The inquiry panel, or the panel chair acting on the panel’s behalf, may consider any evidence or information [normally considered by the board’s inquiry panels] in making a charging decision[decision] pursuant to KRS 311.591(3) or in making the determination whether to issue an emergency order pursuant to Section 1 of this administrative regulation. The [Such] evidence or information may include:

(a) An application [Applications] for licensing or renewal filed by the physician with [this or any] other licensing board;

(b) Any prior or current order issued by the board or one (1) of its panels affecting the physician’s Kentucky license;

(c) Any prior or current order issued by another state’s licensing authority affecting the physician’s license in that state;

(d) The records of any criminal proceeding involving the physician;

(e) A report by or record of any governmental agency, including a law enforcement agency report, [agencies, and including] Kentucky All Schedule Prescription Electronic Reporting (KASPER) report or summary, or a reference to a governmental agency or KASPER report[reports or summaries of or references to such reports];

(f) Patient records maintained by the physician, or summaries of references to the contents of those [such] records;

(g) Records or reports issued or maintained by a pharmacy [pharmacies];

(h) Records or reports issued or maintained by a hospital, including a peer review report[hospitals, including peer review reports] relating to the physician [and] medical records of a patient[patients] treated by the physician in the hospital;

(i) Records or reports issued or maintained by any business:

(i) An investigative report[reports] prepared by a board investigator, including any summary of a verbal or written statement by a witness or an evidentiary document reviewed by an investigator[the board’s investigators, including summaries of verbal or written statements by witnesses and summaries of evidentiary documents reviewed by the investigators];

(k) An investigative report prepared by a board investigator involving another investigation[reports prepared by the board’s investigators involving other investigations] conducted by the board relating to the physician;

(l) An oral or written statement[statements] by the physician, or the physician’s agent, relating to the investigation;

(m) A report of a clinical assessment[Reports of clinical assessments] relating to the physician, including a report[reports] by the Center for Personalized Education for Physicians (CPEP), Denver, Colorado;

(n) A physical, mental, or substance abuse evaluation or assessment[Physical or mental evaluations or assessments] of the physician;

(0) A written report of [Written reports of] patient record reviews[reviews] conducted by a consultant under contract with the board to perform [such] reviews; or

(p) A written report of [Written reports of] patient record review[reviews] conducted by a licensed physician performing a [such] review on behalf of the physician.

(2) The evidence or information considered by the inquiry panel or panel chair, acting on behalf of the inquiry panel, shall constitute the board’s record of proceedings relating to the issuance of an emergency order of restriction or suspension.

(3) If the inquiry panel or the panel chair, acting on behalf of the inquiry panel, issues an emergency order of restriction or suspension against a physician’s license, the emergency order shall be a written order and shall include findings of fact and conclusions of law, supported by the board’s record of proceedings, upon which the agency bases the emergency order.

(4) Any emergency order [Issued by the inquiry panel or panel chair, acting on behalf of the inquiry panel,] shall be served upon the affected physician in the manner specified in KRS 13B.050(2). The emergency order shall become effective immediately upon receipt by the affected physician or the physician’s representative.

Section 3. Authority to Issue Emergency Order of Suspension Upon Felony Indictment. (1) If a licensee is indicted in any state for a crime classified as a felony in that state and the conduct charged relates to a controlled substance[substances], that licensee’s practice shall be considered an immediate danger to the public health, safety, or welfare pursuant to KRS 311.592 and 13B.125.

(2) If the board receives verifiable information that a licensee has been indicted in any state for a crime classified as a felony in the state of indictment and the conduct charged relates to a controlled substance[substances], the inquiry panel or panel chair, acting on behalf of the inquiry panel, shall immediately issue an emergency order suspending or restricting that licensee’s Ken-
tucky license to prohibit the licensee from prescribing, dispensing, or otherwise utilizing a controlled substance in Kentucky, until further order following the final resolution of the criminal charges in the indictment.

(3) The emergency order of suspension shall remain in effect until:
   
   (a) such time as the criminal charges contained in the indictment are finally resolved; and
   
   (b) the board’s hearing panel has finally resolved the matter after receipt of the court documents finally resolving the criminal charges in the indictment.

(4) If the affected physician requests an emergency hearing, the hearing officer shall affirm the emergency order of suspension if presented with a certified copy of the indictment.

Section 4. Request for and Timing of Emergency Hearing:

Waiver. (1) A physician required to comply with an emergency order [issued by an inquiry panel or panel chair, acting on behalf of an inquiry panel] may request an emergency hearing at any time between the effective date of the emergency order and the effective date of an order finally resolving the underlying complaint.

(2) (a) Any request for an emergency hearing shall be presented to the board in writing, but may be submitted by facsimile or email.

   (b) Upon receipt of a written request for an emergency hearing, the board shall schedule the emergency hearing on one (1) of the ten (10) working days following the date of receipt of the written request. If the day on which the written request is received by the board shall not be considered one (1) of the ten (10) working days specified in the statute’s requirement.

(3) A written request for an emergency hearing shall be considered received on a particular work day if it is received by the board during the board’s scheduled operating hours for that day. If the board receives a request for an emergency hearing by facsimile or email received after scheduled operating hours, the request shall be considered to have been received the next scheduled work day of the board.

(4) A written request for an emergency hearing shall be considered a certification by the affected physician and the physician’s counsel, if any, that the physician is available to participate in an emergency hearing on any of the ten (10) working days following the date of the board’s receipt of the written request for an emergency hearing.

(5) The refusal of the physician to accept a hearing date on a date specified by the board within the ten (10) working days allotted to the board to conduct the emergency hearing shall constitute a waiver of the requirement of KRS 13B.125(3) to conduct the emergency hearing within ten (10) working days of receipt of a request.

(6) If there is a waiver of the ten (10) working day requirement of the statute, the hearing officer and parties shall schedule the emergency hearing to commence at the next date available to the hearing officer and both parties.

(7) Unless there is a waiver of the requirement, the board shall commence the emergency hearing within ten (10) working days of receipt of the written request for an emergency hearing.

(8) If the parties are unable to conclude the emergency hearing on the initial date assigned, the emergency hearing shall resume on the next date available to the hearing officer and both parties and shall continue on dates available to the hearing officer and both parties until concluded.

Section 5. Scope and Conduct of Emergency Hearing:

Hearing Officer’s Role. (1) The emergency hearing shall be conducted by the inquiry panel, or its panel chair, acting on behalf of the inquiry panel, or by a qualified hearing officer appointed by the board’s executive director.

(2) The singular function of the party conducting the emergency hearing shall be to determine whether the findings of fact providing the bases for the emergency order are supported by substantial evidence and, if so, constitute one (1) or more violations of KRS 311.595.

(3) Given the ten (10) working day requirement of KRS 13B.125(3) and the unique nature of the hearing, it shall not be appropriate to conduct the emergency hearing in conformity with the provisions of KRS 13B.050, 13B.060, 13B.070, 13B.080(2), 13B.080(3)(a) it relates to discovery orders) or (4)(to the extent it conflicts with this administrative regulation); or KRS 13B.090(1)(to the extent it prohibits consideration of hearsay evidence), (2)(other than the requirement that all testimony shall be made under oath or affirmation), (3) or (7); KRS 13B.110 or 13B.120.

(4) There shall not be a motion practice, prior to or as part of the emergency hearing, relating to the legality or validity of the emergency order under consideration or relating to evidentiary issues.

(5) As the agency specifically charged by statute with the regulation of the practice of medicine and osteopathy within the Commonwealth of Kentucky, the board has determined that the standards of acceptable and prevailing medical practice within the Commonwealth may be determined and by an expert review of a physician’s patient records by a qualified expert.

(6) An expert review may be conducted on the board’s behalf by a licensed physician, who has entered into a contractual relationship with the board, to serve as a contractual reviewer or by the inquiry panel or panel chair, acting on behalf of an inquiry panel or panel chair, acting on behalf of the inquiry panel or panel chair, acting on behalf of the inquiry panel.

(7) The contractual relationship shall be entered into by the board, the inquiry panel, or the panel chair, acting on behalf of an inquiry panel, with such physicians as the board shall determine.

(8) The contractual relationship shall indicate that the physician(s) is/are legally qualified to provide an expert opinion, to determine whether the affected physician has violated those standards or committed other professional violations of the board’s statutes. Pursuant to KRS 13B.090(5), upon receipt of a written request for an emergency hearing, the hearing officer conducting the emergency hearing shall issue a notice to the affected physician[s]; the inquiry panel or panel chair, acting on behalf of the inquiry panel.

(9) The hearing officer conducting the emergency hearing shall provide the affected physician[s] with a copy of the notice, the hearing officer conducting the emergency hearing shall provide to the affected physician[s] the record of proceedings relating to the issuance of the emergency order, and the hearing officer conducting the emergency hearing shall provide to the affected physician[s] the record of proceedings relating to the issuance of the emergency order.

(10) If the parties are unable to conclude the emergency hearing on the initial date assigned, the affected physician[s] may testify, as if under cross-examination, regarding the factual accuracy of the findings and opinions within the board’s specialized knowledge, shall accept the board’s determination of the affected physician[s] ability to establish the factual accuracy of the evidence or information and shall recognize that the inquiry panel or panel chair, acting on the board’s behalf, may consider and accept those opinions rendered as part of a contractual review of the physician’s practice.

(11) The party conducting the emergency hearing shall not conduct a separate hearing or inquiry into the qualifications of the contractual reviewer who reviewed the record review on behalf of the board of or of a licensed physician who performed a record review on behalf of the affected physician.

(12) The emergency hearing shall be conducted as required by KRS Chapter 13B and this subsection, in the following manner:

(a) The board shall produce and the hearing officer shall accept the record of the proceedings relating to the issuance of an emergency order under consideration.

(b) If the board shall not be required to produce any further evidence to support the emergency order.

(c) The affected physician may testify. The affected physician may testify. [May] produce factual evidence, produce hearsay evidence through documents, or call lay witnesses to the extent that evidence specifically tends to demonstrate that a factual statement relied upon by the board’s contractual reviewer or by the inquiry panel or panel chair,
(d) The affected physician may only call the board's contractual reviewer for the purpose of cross-examination if the hearing officer determines on the record that the physician's evidence has established that one (1) or more factual statements relied upon by the contractual reviewer in the expert report is demonstrably false or incorrect. If the hearing officer makes that determination, the affected party may call the board's contractual reviewer for the purpose of cross-examination under the following conditions:

1. The cross-examination of the board's contractual reviewer is scheduled at the earliest date available to the reviewer and the parties at such scheduling does not disrupt the normal operation of the reviewer's professional practice and does not disrupt the care of the reviewer's normal patients;

2. The affected physician shall reimburse the contractual reviewer for the time spent testifying at the emergency hearing and shall tender the expected reimbursement to the reviewer prior to the reviewer's appearance at the emergency hearing;

3. The cross-examination of the board's contractual reviewer is limited to factual statements and opinions rendered in the reviewer's report, and the effect upon an opinion of such opinions of a determination that one (1) or more underlying factual statements relied upon by the reviewer is false or factually incorrect;

4. Upon completion of the cross-examination, the board and the hearing officer may ask questions of the contractual reviewer relevant to the cross-examination.

(b) If a facility meets the criteria established by this definition, it is a "Pain Management Facility" for purposes of this regulation. One or more Pain Management Facilities shall include: (a) "Pain Management Facility" means any facility where the majority of the patients receiving treatment from the practitioners at the facility are provided treatment for pain that includes the use of controlled substances, and:

1. The facility's primary practice component is the treatment of pain that includes the use of controlled substances, and:

   a. The facility's primary practice component is the treatment of pain that includes the use of controlled substances;

   b. The facility advertises in any medium for any type of pain management services;

   c. The facility advertise in any medium for any type of pain management services.

   (b) A facility meets the criteria outlined in paragraph (a) of this subsection, it will be considered "a pain management facility" regardless of whether the owners or operators of the facility have designated the facility as an "urgent treatment center," "internal medicine practice," "general medicine practice," "family practice," "private clinic," or some other type of practice;

   (c) "Pain Management Facility" does not include the following:

      1. A hospital defined in KRS Chapter 216, a facility owned by the hospital, or the office of a hospital-employed physician;
2. A school, college, university, or other educational institution or program to the extent that it provides instruction to individuals preparing to practice as physicians, podiatrists, dentists, nurses, physician assistants, optometrists, or veterinarians;

3. A hospice program or residential hospice facility licensed under KRS Chapter 216B;

4. An ambulatory surgical center licensed under KRS Chapter 216B or Chapter 216C;

5. A long-term care facility licensed under KRS Chapter 216B or Chapter 216C.

(2) For the purposes of subsection (1) of this section, “practitioner” includes physicians, nurses, physician assistants, acupuncturists, and any other licensed health care practitioner.

(3) “Cabinet” means the Cabinet for Health and Family Services.

(4) “Board” means the Kentucky Board of Medical Licensure.

(5) “License in good standing” means an active license to practice medicine or osteopathy that is not currently subject to any final order, agreed order, emergency order, interim agreed order of any nature, or letter of agreement issued by or entered into with the Board.

Section 2. Ownership or Investment Interest. (1) No person, other than a physician who is currently licensed to practice medicine or osteopathy within the Commonwealth of Kentucky and whose Kentucky medical or osteopathic license is presently in good standing, shall have an ownership or investment interest in a pain management facility that is formed or comes into existence after April 24, 2012, or in a pain management facility existing on April 24, 2012, if there has been an administrative sanction or criminal conviction relating to controlled substances imposed upon the facility or upon any person employed by the facility for an act or omission done within the scope of the facility’s licensing or the person’s employment.

(b) Any person may have an ownership or investment interest in a pain management facility that was in existence and operating on April 24, 2012, unless there is an administrative sanction or criminal conviction relating to controlled substances imposed upon the facility or upon any person employed by the facility for an act or omission done within the scope of the facility’s licensing or the person’s employment. If the facility or one (1) or more of its employees sustains such an administrative sanction or criminal conviction, only a physician licensed in good standing in Kentucky may have an ownership or investment interest in the facility from the date of the sanction or conviction forward.

(c) Credit extended by a financial institution as defined in KRS 136.500 to the facility shall not be deemed an investment interest under this subsection.

(d) A physician who has an ownership or investment interest in a pain management facility during any period when the physician is not licensed to practice medicine or osteopathy in the Commonwealth of Kentucky shall be deemed to:

1. In violation of KRS 311.595(12); and
2. [shall be deemed to] Practicing medicine without a license and subject to criminal sanctions.

(b) If the board determines that a physician has maintained an ownership or investment interest in a pain management facility during a period when that physician was not licensed to practice medicine or osteopathy within the Commonwealth of Kentucky, it may deny an application for licensing filed by that physician or may take appropriate disciplinary action against a license previously issued to the physician.

(e) A physician who maintains an ownership or investment interest in a pain management facility during any period when the physician’s Kentucky license is not in good standing shall be in violation of KRS 311.595(12) and subject to disciplinary action by the Board.

Section 3. Divestiture of Ownership or Investment Interest. (1) A physician who has an ownership or investment interest in a pain management facility shall immediately divest himself or herself of that ownership or investment interest if: when:

(a) The physician’s Kentucky license is no longer active for any reason; or

(b) The physician’s Kentucky license becomes subject to any final order imposing any disciplinary sanction authorized by KRS 311.595, agreed order, emergency order, interim agreed order of any nature, or letter of agreement issued by or entered into with the board.

(2)(a) If a physician fails to immediately divest himself or herself of the ownership or investment interest in the pain management facility as required by subsection (1) of this section, the board may institute an action for injunctive relief pursuant to KRS 311.605(3) and (4) to require the physician to immediately divest himself or herself of the ownership or investment interest in the pain management facility.

(b) An unlawful ownership or investment interest in a pain management facility shall be considered the unlawful practice of medicine and shall be considered to cause irreparable injury to the Commonwealth, acting through this board.

Section 4. Registration; Amended Registration; Fee; New Facility Registration. (1)(a) On or before September[August] 1, 2012 and September[August] 1 of each succeeding year, every pain management facility operating as the private office or clinic of a physician within the Commonwealth of Kentucky shall register with the board, providing the following specific information in writing:

(a) [1] The name, business address, profession, current professional licensing status and nature and extent of ownership or investment interest of each person who has or maintains an ownership or investment interest in the pain management facility. [For each person who has or maintains an ownership or investment interest in the pain management facility, the facility will report whether that person has an ownership or investment interest in any other pain management facility operating within the Commonwealth of Kentucky and, if so, the name and address of the other pain management facility(ies) in which the person has an ownership or investment interest:]

(b) [2] The names and addresses of every practice location owned and operated by that pain management facility in which the person has an ownership or investment interest:]

(c) [3] The hours of operation of every practice location owned and operated by that pain management facility:]

(d) [4] The names and professional status of each employee at each practice location owned and operated by that pain management facility:]

(e) [5] The name, professional license number, and practice address of the qualified physician owner or owner’s physician designee who is a physician and will be physically present practicing medicine in the pain management facility for at least fifty (50) percent of the time patients are present at the facility. The facility shall also state its plan for ensuring that the designated physician owner or owner’s physician designee will be physically present practicing medicine in the facility and, if the facility owns and operates multiple practice locations, the plan to ensure that a physician owner or owner’s physician designee is physically present practicing medicine in each practice location for at least fifty (50) percent of the time that patients are seen at each pain management facility:]

(f) An attestation by the physician owner that the owner or owner’s physician designee will fulfill the oversight responsibilities as the private office or clinic of a physician owner or owner’s physician designee:

(g) An attestation by the physician owner or owner’s physician designee who is a physician and whose Kentucky medical or osteopathic license is not in good standing shall:

1. In violation of KRS 311.595(12); and
2. [shall be deemed to] Practicing medicine without a license and subject to criminal sanctions.

(h) If the board determines that a physician has maintained an ownership or investment interest in a pain management facility during a period when that physician was not licensed to practice medicine or osteopathy within the Commonwealth of Kentucky, it may deny an application for licensing filed by that physician or may take appropriate disciplinary action against a license previously issued to the physician.

(i) A physician who maintains an ownership or investment interest in a pain management facility during any period when the physician’s Kentucky license is not in good standing shall be in violation of KRS 311.595(12) and subject to disciplinary action by the Board.
...
the practice location during that period.

Section 7. [Methods of Payment. (1) Each pain management facility shall accept private health insurance as one (1) of the facility’s allowable forms of payment for goods and services provided, so long as the goods or services provided are covered under the applicable health insurance plan.

(2) Each pain management facility shall accept payment for services rendered or goods provided to a patient only from the patient or from the patient’s insurer, guarantor, spouse, parent, guardian, or legal custodian.

Section 8. Record-Keeping; Inspection. (1) Each pain management facility shall document on a weekly basis that a physician owner or an owner’s physician designee who is employed by and under the direct supervision of the owner was physically present practicing medicine in the facility for at least fifty (50) percent of the time that patients were present in the facility during that week. This documentation shall include:

(a) The name, practice address, and phone number of the physician owner or physician designee who fulfilled this oversight function for that specific week;

(b) The practice address of each practice location owned and operated by that pain management facility;

(c) The days and hours each practice location of the pain management facility was open to patients during that specific week; and

(d) The days and hours the physician owner or physician designee was present in each practice location for the pain management facility for that specific week.

(e) A listing of the patients treated by the physician owner or physician designee during that specific week.

(2) Each pain management facility shall maintain appropriate records of the patients receiving treatment at that facility so that the board may determine the identity and number of patients treated during any given time period, also utilize and maintain daily sign-in sheets, that include the legible name of each patient seen by the practice or facility on that day, for each and every day that the practice or facility is open to patients or the public, for each practice location of the practice or facility.

(3) The pain management facility shall maintain the weekly reports required by subsection (1) of this section and any daily sign-in sheets maintained by the practice and the daily sign-in sheets required by subsection (2) of this section on site in a readily accessible location for a minimum period of six (6) years.

(4) Upon request by an employee or agent of the board, the pain management facility shall permit the board employee or agent to inspect and copy the weekly reports and daily sign-in sheets maintained on site.

(5) For the purpose of enforcing the provisions of this administrative regulation, an agent of the board shall have the power and authority to:

(a) Enter upon professional premises during periods when those premises are otherwise open to patients or the public;

(b) Obtain evidence, including but not limited to, psychiatric or nonpsychiatric patient records, by consent or pursuant to a subpoena or search warrant;

(c) Interview all persons including owners, employees, or patients; and

(d) Require the production of books, papers, documents, or other documentary evidence either by consent or pursuant to a subpoena or search warrant.

Section 9. [Physical Environment. (1) Each pain management facility shall meet each of the requirements for the physical environment of the facility as set out in 902 KAR 20:420.

(2) Each individual failure of a physician who has an ownership or investment interest in a pain management facility to fully comply with the requirements of 902 KAR 20:420, Section 9, shall constitute a separate violation of KRS 311.595(9) and (12).

Section 10. Violations; Enforcement; Emergency Action. (1) Any violation of the requirements of this administrative regulation shall constitute a violation of KRS 311.595(12) and (9), as illustrated by KRS 311.597(4) and may constitute a violation of KRS 311.595(9), as illustrated by KRS 311.597(3) given the circumstances.

(2) In order to lawfully prescribe or dispense controlled substances within the Commonwealth of Kentucky while practicing at a pain management facility, a licensee must practice in a lawful pain management facility.

(3) A pain management facility shall be considered an unlawful pain management facility if:

(a) Permits an unqualified person to gain or maintain ownership or investment interest in the pain management facility; or

(b) Fails to ensure that a qualified physician owner or physician designee is physically present practicing medicine in the facility for at least fifty (50) percent of the time that patients are present in the facility.

(4) Prescribing or dispensing controlled substances within the Commonwealth of Kentucky while employed by or practicing in an unlawful pain management facility within the Commonwealth of Kentucky shall constitute a violation of KRS 311.595(9) and (12) which constitutes an immediate danger to the public health, safety, or welfare of the public, for the purposes of KRS 311.592 and 13B.125.

(5) If the board receives proof that a licensed physician is prescribing or dispensing a controlled substance within the Commonwealth of Kentucky unlicensedly, the board shall promptly issue an emergency order restricting that licensee from prescribing or dispensing a controlled substance within the Commonwealth of Kentucky unless that licensee has provided sufficient proof that the licensee is no longer employed by or practicing in an unlawful pain management facility.

(6) An emergency order restricting a licensee from prescribing or dispensing a controlled substance within the Commonwealth of Kentucky issued pursuant to subsection (5) of this section shall remain valid and in effect until the board has

2. One (1) of the following additional conditions was present during that thirty (30) day period as required by KRS 218A.175(1)(a):

(a) A primary component of the practice was the treatment of pain; or

(b) The facility advertised in any medium for any type of pain management services.

The facility met the definition of a pain management facility if:

(a) For any selected thirty (30) day period, the majority of patients receiving medical treatment from the clinic, practice, or facility received controlled substances or a prescription for controlled substances during that period; and

(b) The facility advertised in any medium for any type of pain management services.

The facility advertised in any medium for any type of pain management services if:

(a) The practice was the treatment of pain; or

(b) The facility advertised in any medium for any type of pain management services.
received sufficient proof that the licensee is no longer employed by or practicing in an unlawful pain management facility. Upon receipt of that [such sufficient] proof, the panel or its chair shall [will] immediately issue an order terminating the emergency order issued pursuant to subsection (5) of this section requests an emergency hearing pursuant to KRS 13B.125(3), the hearing officer conducting the emergency hearing shall affirm the emergency order if presented with substantial evidence that the licensee was prescribing or dispensing controlled substances within an unlawful pain management facility.

(7) If a licensee who is affected by an emergency order issued pursuant to subsection (5) of this section requests an emergency hearing pursuant to KRS 13B.125(3), the hearing officer conducting the emergency hearing shall affirm the emergency order if presented with substantial evidence that the licensee was prescribing or dispensing controlled substances within an unlawful pain management facility.

(8) If a licensee prescribes or dispenses a controlled substance should prescribe or dispense controlled substances] within the Commonwealth of Kentucky during any period when the licensee is employed by or practicing in an unlawful facility, each instance of prescribing or dispensing shall constitute a separate violation of KRS 311.595(12) and (9), as illustrated by KRS 311.597(1)(b) and shall [will] serve as the basis for disciplinary sanctions pursuant to KRS [Chapter] 311.595.

Section 10.11. Periodic KASPER Reviews. (1) The board shall have the authority pursuant to KRS 218A.202 and 218A.240 to obtain KASPER reports and analyses for each practitioner practicing in a pain management facility.

(2) At least once each year, the board shall obtain a KASPER review and analysis for each physician who has or maintains an ownership or investment interest in, or is employed by, or practices in, a pain management facility to determine whether improper, inappropriate, or illegal prescribing is occurring. If the board determines that there is evidence to indicate that improper, inappropriate, or illegal prescribing is occurring, the board shall initiate an investigation of that physician and notify the appropriate agencies of its investigation.

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: July 20, 2012
FILED WITH LRC: July 20, 2012 at 2 p.m.
CONTACT PERSON: C. Lloyd Vest II, General Counsel, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, phone (502) 429-7150, fax (502) 429-7118.

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(As Amended at ARRS, January 7, 2013)


RELATES TO: KRS 218A.205, 311.530-311.620, 311.990
STATUTORY AUTHORITY: KRS 218A.205(3)(a), 311.565(1)(a)

NECESITY, FUNCTION, AND CONFORMITY: KRS 311.565(1)(a) authorizes the board to promulgate administrative regulations to regulate the conduct of its licenses. KRS 218A.205(3)(a) requires the board to establish mandatory prescribing and dispensing standards related to controlled substances. This administrative regulation establishes the professional standards for prescribing and dispensing controlled substances. Each physician who is authorized to prescribe or dispense controlled substances shall conform to the following mandatory professional standards relating to controlled substances while practicing within the Commonwealth of Kentucky. The following standards shall be considered the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky for prescribing and dispensing controlled substances for the various conditions or settings described, subject to the enumerated exceptions.

Section 1. Applicability/Exceptions. (1) A physician who is authorized to prescribe or dispense a controlled substance shall comply with the requirements established in KRS 218A.172 and this administrative regulation.

(2) The standards of acceptable and prevailing medical practice for prescribing and dispensing a controlled substance in Kentucky shall include:

(a) [These exceptions do not apply to] The standards for Schedule II controlled substances and Schedule III controlled substances with hydrocodone established in KRS 218A.172;

(b) The requirements established in this administrative regulation;

(3) The professional standards established in this administrative regulation shall not apply to a physician prescribing or dispensing a controlled substance:

(a) To a patient as part of the patient’s hospice or end-of-life treatment;

(b) To a patient admitted to a licensed hospital as an inpatient, outpatient, or observation patient, during and as part of a normal and expected part of the patient’s course of care at that hospital;

(c) To a patient for the treatment of pain associated with cancer or with the treatment of cancer;

(d) To a patient who is a registered resident of a long-term care facility as defined in KRS 216.510;

(e) During the effective period of any period of disaster or mass casualties which has a direct impact upon the physician’s practice;

(f) In a single dose prescribed or dispensed to relieve the anxiety, pain, or discomfort experienced by that patient submitting to a diagnostic test or procedure; or

(g) That has been classified as a Schedule V controlled substance.

Section 2. Professional Standards for Documentation of Patient Assessment, Education, Treatment Agreement and Informed Consent, Action Plans, Outcomes and Monitoring. (1) Each physician prescribing or dispensing a controlled substance shall obtain and document all relevant information in a patient’s medical record in a legible manner and in sufficient detail to enable the physician to:

(a) This] board to determine whether the physician is conforming to professional standards for prescribing or dispensing controlled substances and other relevant professional standards.

(2) If a physician is unable to conform to professional standards for prescribing or dispensing controlled substances due to circumstances beyond the physician’s control, or the physician makes a professional determination that it is not appropriate to comply with a specific standard, based upon the individual facts applicable to a specific patient’s diagnosis and treatment, the physician shall document those circumstances in the patient’s record and only prescribe or dispense a controlled substance to the patient if [when] the patient record appropriately justifies the prescribing or dispensing of a controlled substance under the circumstances.

Section 3. Professional Standards for the Prescribing or Dispensing of Controlled Substances for the Treatment of Pain and Related Symptoms Associated with a Primary Medical Complaint. (1) Prior to the initial prescribing or dispensing of any controlled substance for pain or other symptoms associated with the same primary medical complaint, the first physician prescribing or dispensing a controlled substance shall:

[1] [a] Obtain an appropriate medical history relevant to the medical complaint, including a history of present illness, and

(a) If the complaint does not relate to a psychiatric condition, conduct a physical examination of the patient relevant to the medical complaint and related symptoms; for all medical complaints other than psychiatric conditions, and document the information in the patient’s medical record; or
(b) If the complaint relates to a psychiatric condition, Psychiatrists, or other designated mental health providers, shall perform, or have performed by a psychiatrist or other designated mental health provider, an evaluation appropriate to the presenting complaint and document the relevant findings;

(2)(b) Obtain and review a KASPER report for that patient for the twelve (12) month period immediately preceding the patient encounter, and appropriately utilize that information in the evaluation and treatment of the patient;

(3)(c) After examining the benefits and risks of prescribing dispensing a controlled substance to the patient, including nontreatment or other treatment, make a deliberate decision that it is medically appropriate to prescribe or dispense the controlled substance in the amount specified;

(4)(d) Not prescribe or dispense a long-acting or controlled-release opioid to a patient for acute pain that is not directly related to and close in time to a specific surgical procedure;

(5)(e) Explain to the patient a controlled substance used to treat an acute medical condition is for time-limited use, and that the patient should discontinue the use of the controlled substance when the condition requiring the controlled substance use has resolved;

(6)(f) Explain to the patient how to safely use and properly dispose of any unused controlled substance.

Section 4. Professional Standards for Commencing Long Term Use of Prescribing or Dispensing of Controlled Substances for the Treatment of Pain and Related Symptoms Associated with a History of Substance Use;

(a) Each practitioner involved has lawful access to the patient's medical record;

(b) There is compliance with all applicable standards; and

(c) Each practitioner performing an action to meet the required standards is acting within the practitioner's legal scope of practice.

(2)(a) The physician shall obtain the following information from the patient and record all relevant information in the patient's medical record:

1. History of present illness;

2. Past medical history;

3. History of substance use and any prior treatment for that(such) use by the patient, and history of substance abuse by first degree relatives of the patient;

4. Past family history of relevant illnesses and treatment; and

5. Psychosocial history.

(b) The physician shall conduct an appropriate physical examination of the patient sufficient to support the medical indications for prescribing or dispensing a controlled substance on a long-term basis.

(c) The physician shall perform appropriate baseline assessments to establish beginning values to assist in establishing and periodically evaluating the functional goals of any treatment plan.

(d) If a specific or specialized evaluation is necessary for the formulation of a working diagnosis or treatment plan, the physician shall either convince the use of controlled substance after determining that continued use of the controlled substance is safe and medically appropriate in the absence of that information.

(e) If the physician determines that the patient has previously received medical treatment for the presenting medical complaint or related symptoms and that review of the prior treatment records is necessary to justify long-term prescribing of a controlled substance, the physician shall obtain those prior records and incorporate the information therein into the evaluation and treatment of the patient.

(f) Based upon consideration of all information available, the physician shall promptly formulate and document a working diagnosis of the source of the patient's medical complaint and related symptoms without simply describing or listing it is not sufficient to simply describe or list the related symptoms.

2. If the physician is unable, despite best efforts, to formulate a working diagnosis, the physician shall consider the usefulness of additional information, such as a specialized evaluation or assessment, referral to an appropriate specialist, and the usefulness of further observation and evaluation, before attempting again to formulate a working diagnosis.

3. If the physician is unable to formulate a working diagnosis, despite the use of additional professional evaluation or assessment, the physician shall only prescribe a long-term use of a controlled substance after establishing that its use at a specific level is medically indicated and appropriate.

4. To the extent additional information is medically expected based upon the patient's condition, the physician shall formulate an appropriate treatment plan.

5. The treatment plan shall include specific and verifiable goals of treatment, with a schedule for periodic evaluations.

(b) The physician shall utilize appropriate screening tools to screen each patient to determine if the patient:

(a) Does not have another medical condition which may impact the prescribing or dispensing of a controlled substance;

(b) Presents a significant risk for illegal diversion of a controlled substance;

2. If, after screening, the physician determines that there is a reasonable likelihood that the patient suffers from substance abuse or dependence, or a psychiatric or psychological condition, the physician shall take the necessary actions to facilitate a referral to an appropriate treatment program or provider. The physician shall appropriately incorporate the information from the treatment program or provider into the evaluation and treatment of the patient.

3. If, after screening, the physician determines that there is a risk that the patient may illegally divert a controlled substance, the physician shall use a prescribing agreement that meets professional standards. The prescribing agreement and informed consent document may be combined into one document.

4. The physician shall obtain and document a baseline drug screen.

5. If, after screening, the physician determines that the controlled substance prescribed to the patient will be used is likely to be used other than medicinally or other than for an accepted therapeutic purpose, the physician shall not prescribe any controlled substance to that patient.

(j) After explaining the risks and benefits of long-term use of a controlled substance, the physician shall obtain the written informed consent of the patient in a manner that meets professional standards.

(i) The physician shall initially attempt, to the extent possible, or establish and document a previous attempt by another physician, if a trial of noncontrolled modalities and lower dosage of a controlled substance is necessary in order to treat the pain and related symptoms associated with the primary medical complaint, before continuing with long term prescribing of a controlled substance at a given level.
Section 5. Professional Standards for Continuing Long Term Prescribing or Dispensing of Controlled Substances for the Treatment of Pain and Related Symptoms Associated with a Primary Medical Complaint. (1) If a physician continues to prescribe or dispense a controlled substance beyond three (3) months to a patient sixteen (16) years or older for pain and related symptoms associated with the primary medical complaint, the physician shall comply with the following professional standards established in subsection (2) of this section. These standards may be accomplished by different licensed practitioners in a single group practice at the direction of or on behalf of the prescribing physician as established [set forth] in Section 4(1) of this administrative regulation. 

(2)(a)1. The physician shall ensure that the patient is seen at least once a month initially for evaluation and review of progress. The physician may determine that the patient is to be evaluated less frequently, on a schedule determined by the physician’s professional judgment after the physician has determined:

a. The controlled substance prescribed or dispensed has been titrated to the level appropriate and necessary to treat the medical complaint and related symptoms;

b. The controlled substance prescribed or dispensed is not causing unacceptable side effects; and

c. There is sufficient monitoring in place to minimize the likelihood that the patient will use the controlled substance in an improper or inappropriate manner or divert it for an improper or inappropriate use.

(b) At appropriate intervals, the physician shall:

1. Ensure that a current history is obtained from the patient.

2. [shall ensure that a focused physical examination is considered, and performed, if appropriate.]

3. Perform appropriate measurable examinations as indicated in the treatment plan.

(c) At appropriate intervals, the physician shall evaluate the working diagnosis and treatment plan based upon the information gained to determine whether there has been functional improvement or any change in baseline measures. [If appropriate,] the physician shall modify the diagnosis, treatment plan, or controlled substance therapy, as appropriate.

(d) If the physician determines that the patient presents a significant risk of diversion or improper use of a controlled substance, the physician shall discontinue the use of the controlled substance or justify its continued use in the patient record.

(e) If the medical complaint and related symptoms continue with no significant improvement in function despite treatment with a controlled substance, and if [where] improvement is medically expected, the physician shall obtain appropriate consultative assistance to determine whether there are undiagnosed conditions that must be addressed in order to resolve the medical complaint.

(f) For a patient exhibiting symptoms suggestive of a mood, anxiety, or [and/or] psychotic disorder, the physician shall obtain a psychiatric or psychological consultation for intervention if appropriate.

(g) If a patient reports experiencing episodes of [breakthrough] pain, the physician shall:

1. Attempt to identify the triggers or triggers for each episode;

2. Determine whether the breakthrough pain may be adequately treated through noncontrolled treatment; and

3. If the physician determines that the nonmedication treatments do not adequately address the triggers, and after considering the risks and benefits, the [physician] determines to add an as-needed controlled substance to the regimen, [the physician] shall take appropriate steps to minimize the improper or illegal use of the additional controlled substance.

(h) At least once a year, the physician shall perform or shall ensure that the patient’s primary treating physician performs a preventive health screening and physical examination appropriate to the patient’s gender, age, and medical condition.

(i) At least once every three (3) months, the physician shall obtain and review a current KASPER report and appropriately use that information in the evaluation and treatment of the patient.

2. If the physician obtains or receives specific information that the patient is not taking the controlled substance as directed, is diverting a controlled substance, or is engaged in any improper or illegal use of a controlled substance, the physician shall immediately obtain and review a KASPER report and appropriately use the information in the evaluation and treatment of the patient.

3. If a KASPER report discloses that the patient is obtaining a controlled substance from another practitioner without the physician’s knowledge and approval, in a manner that raises suspicion of illegal diversion, the physician shall promptly notify the other practitioner of the relevant information from the KASPER review.

4. The physician shall obtain consultative assistance from a specialist if [when] appropriate.

5. The physician shall conduct random pill counts and appropriately use that information in the evaluation and treatment of the patient.

6. During the course of long-term prescribing or dispensing of a controlled substance, the physician shall utilize drug screens, appropriate to the controlled substance and the patient’s condition, in a random and unannounced manner at appropriate times. If the drug screen or other information available to the physician indicates that [and, if appropriate, in cases where] the patient is noncompliant, the physician shall:

a. Do a controlled taper;

b. Stop prescribing or dispensing the controlled substance immediately; or

c. Refer the patient to an addiction specialist, mental health professional, pain management specialist, or drug treatment program, depending upon the circumstances.

2. The physician shall discontinue controlled substance treatment if one (1) or more of the following conditions exist:

a. There has been no improvement in function and response to the medical complaint and related symptoms. [If [where]] improvement is medically expected;

b. Controlled substance therapy has produced significant adverse effects; or

c. The patient exhibits inappropriate drug-seeking behavior or diversion.

Section 6. Professional Standards for the Prescribing and Dispensing of Controlled Substances in an Emergency Department. (1) In addition to complying with the standards for the initial prescribing or dispensing of a controlled substance as established [detailed] in Sections 3(4) and 7 of this administrative regulation, a physician prescribing or dispensing a controlled substance for a specific medical complaint and related symptoms to a patient in an emergency department [is strongly discouraged] and shall not routinely:

a. Administer an intravenous controlled substance for the relief of acute exacerbations of chronic pain, unless intravenous administration is the only medically appropriate means of delivery;

b. Provide a replacement prescription for a controlled substance that was [were] lost, destroyed, or stolen;

c. Provide a replacement dose of methadone, suboxone, or subutex for a patient in a treatment program;

d. Prescribe a long-acting or controlled-release controlled substance, such as OxyContin, fentanyl patches,
Dispensing of Controlled Substances for the Treatment of Medical Complaints

Section 7. Professional Standards for the Prescribing and Dispensing of Controlled Substances for the Treatment of Other Conditions. (1) Before initially prescribing or dispensing a controlled substance to a patient, a physician shall:

(a) Obtain an appropriate medical history relevant to the medical complaint, including a history of present illness, and:

(i) Order medical examination of the patient relevant to the medical complaint and related symptoms; (ii) Review the patient's medical record; or

(ii) If the complaint relates to a psychiatric condition, conduct a physical examination of the patient relevant to the medical complaint and related symptoms; (iii) Document the information in the patient's medical record; or

(b) Obtain and review a KASPER report for that patient.

(2) Each violation of the professional standards established in this administrative regulation shall not apply to physicians retained by the board, following a review of the licensee's patient records and other available information including KASPER reports. The professional standards established in this administrative regulation shall not apply to physicians prescribing or dispensing controlled substances to a patient, who is younger than eighteen (18) years of age at the time of prescribing or dispensing, for the treatment of pain, and:

(a) To a patient as part of their hospice or end-of-life treatment; or

(b) To a patient admitted to a licensed hospital, and:

(i) As a direct part of their professional responsibilities in an emergency department and in accordance with the professional standards established in Section 5 of this administrative regulation; (ii) As a direct part of their professional responsibilities in an emergency department and in accordance with the professional standards established in Section 5 of this administrative regulation.

Section 8. Responsibility to Educate Patients Regarding the Dangers of Controlled Substance Use. (1) A physician prescribing or dispensing a controlled substance shall take appropriate steps to educate a patient receiving a controlled substance, to appropriately treat the situational anxiety or depression.

(2) Educational materials relating to these subjects may be found on the board's Web site, www.kbml.ky.gov. (and are incorporated by reference into this administrative regulation).

Section 9. Violations. (1) Any violation of the professional standards established in this administrative regulation or in KRS 218A.172 shall constitute a violation of KRS 311.595(12) and (9), which may result in the imposition of disciplinary sanctions by the board, pursuant to KRS 311.595.

(2) Each violation of the professional standards established in this administrative regulation or in KRS 218A.172 shall be established by expert testimony by one (1) or more physicians retained by the board, following a review of the licensee's patient records and other available information including KASPER reports. The professional standards established in this administrative regulation shall not apply to physicians prescribing or dispensing controlled substances to a patient, who is younger than eighteen (18) years of age at the time of prescribing or dispensing, for the treatment of pain, and:

(a) To a patient as part of their hospice or end-of-life treatment; or

(b) To a patient admitted to a licensed hospital, and:

(i) As a direct part of their professional responsibilities in an emergency department and in accordance with the professional standards established in Section 5 of this administrative regulation; (ii) As a direct part of their professional responsibilities in an emergency department and in accordance with the professional standards established in Section 5 of this administrative regulation.

(2) These exceptions do not apply to the standards established in KRS 218A.172.

Section 2. Professional Standards for Initial Prescribing or Dispensing of Controlled Substances. Prior to the initial prescribing or dispensing of any controlled substance for a specific medical complaint and related symptoms, each physician shall:

(a) Verify the identity of the patient by a current and valid government-issued photographic identification. If the physician does not have a copy of that identification in the patient's medical record, that physician shall ensure that the identification is copied and placed in the patient's medical record for future reference; (b) Obtain an appropriate medical history relevant to the medical complaint, including a history of present illness, and conduct a physical examination of the patient relevant to the medical complaint and related symptoms; (c) Document the information in the patient's medical record; (d) Obtain and review a KASPER report for all available data on the patient, document relevant information in the patient's record, and consider the available information to determine whether it is medically appropriate and safe to prescribe or disperse controlled substances. This requirement to obtain and review a KASPER report shall not apply to:

1. A physician prescribing or dispensing controlled substances to a patient, who is younger than eighteen (18) years of age at the time of prescribing or dispensing, for the treatment of Attention-Deficit Hyperactive Disorder or Attention Deficit Disorder; or

2. A physician prescribing or dispensing Schedule IV or V controlled substances other than those listed in this specific subsection. The physician shall obtain and review a KASPER report before initially prescribing or dispensing any of the

or methadone or a replacement dose(doses) of that medication(s). (e) Administer Meperidine to the patient; or

(f) Prescribe or dispense more than the minimum amount medically necessary to treat the patient's medical condition until the patient can be seen by the[their] primary treating physician or another physician, with or without refills. If the controlled substance prescription exceeds seven (7) days in length, the patient record shall/must justify the amount of the controlled substance prescribed.

Section 9. Violations. (1) Any violation of the professional standards established in this administrative regulation or in KRS 218A.172 shall constitute a violation of KRS 311.595(12) and (9), which may result in the imposition of disciplinary sanctions by the board, pursuant to KRS 311.595.

(2) Each violation of the professional standards established in this administrative regulation or in KRS 218A.172 shall be established by expert testimony by one (1) or more physicians retained by the board, following a review of the licensee's patient records and other available information including KASPER reports. The professional standards established in this administrative regulation shall not apply to physicians prescribing or dispensing controlled substances to a patient, who is younger than eighteen (18) years of age at the time of prescribing or dispensing, for the treatment of pain, and:

(a) To a patient as part of their hospice or end-of-life treatment; or

(b) To a patient admitted to a licensed hospital, and:

(i) As a direct part of their professional responsibilities in an emergency department and in accordance with the professional standards established in Section 5 of this administrative regulation; (ii) As a direct part of their professional responsibilities in an emergency department and in accordance with the professional standards established in Section 5 of this administrative regulation.

(2) These exceptions do not apply to the standards established in KRS 218A.172.

Section 2. Professional Standards for Initial Prescribing or Dispensing of Controlled Substances. Prior to the initial prescribing or dispensing of any controlled substance for a specific medical complaint and related symptoms, each physician shall:

(a) Verify the identity of the patient by a current and valid government-issued photographic identification. If the physician does not have a copy of that identification in the patient's medical record, that physician shall ensure that the identification is copied and placed in the patient's medical record for future reference; (b) Obtain an appropriate medical history relevant to the medical complaint, including a history of present illness, and conduct a physical examination of the patient relevant to the medical complaint and related symptoms; (c) Document the information in the patient's medical record; (d) Obtain and review a KASPER report for all available data on the patient, document relevant information in the patient's record, and consider the available information to determine whether it is medically appropriate and safe to prescribe or disperse controlled substances. This requirement to obtain and review a KASPER report shall not apply to:

1. A physician prescribing or dispensing controlled substances to a patient, who is younger than eighteen (18) years of age at the time of prescribing or dispensing, for the treatment of Attention-Deficit Hyperactive Disorder or Attention Deficit Disorder; or

2. A physician prescribing or dispensing Schedule IV or V controlled substances other than those listed in this specific subsection. The physician shall obtain and review a KASPER report before initially prescribing or dispensing any of the

or methadone or a replacement dose(doses) of that medication(s). (e) Administer Meperidine to the patient; or

(f) Prescribe or dispense more than the minimum amount medically necessary to treat the patient's medical condition until the patient can be seen by the[their] primary treating physician or another physician, with or without refills. If the controlled substance prescription exceeds seven (7) days in length, the patient record shall/must justify the amount of the controlled substance prescribed.
following Schedule IV controlled substances:

(a) Ambien;
(b) Anorexics;
(c) Alivan;
(d) Klonopin;
(e) Librium;
(f) Nubain;
(g) Oxazepam;
(h) Phentermine;
(i) Soma;
(j) Stadol;
(k) Stadol NS;
(l) Tramadol;
(m) Valium;
(n) Versed; and
(o) Xanax; or

3. A physician who is unable to obtain and review a KASPER report in a timely manner for reasons beyond the physician’s control may prescribe controlled substances in the absence of the report. For this exception, the physician shall document as soon as possible the circumstances that made it impossible to obtain and review a KASPER report before prescribing and the reasons the physician determined it was medically appropriate to prescribe controlled substances in the absence of the report. For this exception, the KASPER report for another practitioner shall be considered in the decision to prescribe or dispense controlled substances in the absence of a KASPER report.

4. After examining the benefits and risks of prescribing or dispensing controlled substances to a patient, including non-treatment or other treatment, the physician shall make a deliberate decision that it is medically appropriate to prescribe or dispense the controlled substances in the amount specified. When the identified risks are significant or unique, the physician shall document the decision to prescribe or dispense controlled substances in the absence of a KASPER report.

5. Avoid providing more controlled substances than necessary by prescribing or dispensing only the amount of controlled substances needed to treat the specific medical complaint, for a definite, pre-determined time period.

6. Not prescribe or dispense long-acting or controlled-release opioids (e.g., OxyContin, fentanyl patches, and methadone) for acute pain.

7. Explain to the patient that controlled substances used to treat an acute medical complaint are for time-limited use, and that the patient should discontinue the use of controlled substances when the condition requiring the controlled substances has resolved.

8. Explain to the patient how to safely and properly dispose of any unused controlled substances.

Section 3. Professional Standards to Commence the Long-Term Use of Any Controlled Substance. Before a physician continues to prescribe or dispense any controlled substance to a patient for a medical complaint or its associated symptoms for a total period of longer than three (3) months, the physician shall comply with the following mandatory professional standards:

Patient History. (1) The physician shall obtain the following information from the patient and record all relevant information in the patient’s medical record in a legible manner, in sufficient detail to provide for meaningful diagnosis and treatment of the patient: (a) All questions are completely answered; (b) Any material conflict in the answers is clarified with the patient; (c) Complete information is obtained regarding any significant disclosure; and, (d) All relevant information is incorporated into the patient’s record and utilized in the development of the working diagnosis.

Physical Evaluations and Assessments. (1) The physician shall conduct a comprehensive physical examination of the patient for all medical conditions and related symptoms, other than psychiatric conditions, and properly document the findings of each evaluation or assessment in the patient’s record, including but not limited to:

(a) Physical examination addressing the medical complaint and related symptoms of a sufficient degree to support the medical indications for prescribing or dispensing controlled substances on a long-term basis;
(b) Measurable examinations that will establish baselines and will assist in establishing and periodically evaluating the functional goals of any treatment plan.

Obtaining Medical Records from Other Practitioners. (1) If the physician determines that the patient has previously received medical treatment for the presenting medical complaint or related symptoms and that review of the prior treatment records is necessary to justify long-term prescribing of controlled substances, the physician shall request a copy of the other physician’s records regarding the patient as quickly as possible, in order to incorporate such information into the working diagnosis and treatment plan.

(2) If the physician has requested a copy of the other physician’s records and has not received them within a reasonable time, the physician will take appropriate steps to follow up and obtain such records. If the physician is unable, after reasonable attempts, to obtain the relevant records, the physician shall document the efforts made to obtain the records, the failure to receive the records, and the impact the inability to obtain such records has upon the physician’s decision whether to continue or modify treatment, particularly the use of controlled substances, for that patient.

(3) Each physician, who receives a written request from another physician for a copy of records relating to that physician’s prior treatment of a specific patient, shall promptly provide a copy of the patient’s medical record to the requesting physician.

Establishing a Working Diagnosis. (1) Based upon consideration of all information available, the physician shall promptly formulate and document a working diagnosis of the essence of the patient’s medical complaint and related symptoms. It is not sufficient to simply describe or list the related symptoms; (2) If the physician is unable, despite best efforts, to formulate a working diagnosis, the physician shall consider the usefulness of additional information, such as specialized
elevations or assessments, referral to appropriate specialists, usefulness of further observation and evaluation, before attempting again to formulate a working diagnosis;

(2) If the physician is unable, despite best efforts, to formulate a working diagnosis, the physician must determine whether long-term use of controlled substances is indicated and appropriate. The physician may determine that a different or lower level of treatment is more appropriate until a working diagnosis can be established;

(4) The physician shall document the working diagnosis or all of the efforts taken in their unsuccessful attempt to formulate a working diagnosis and the reasons for their decision whether or not to utilize controlled substances on a long-term basis in the absence of a working diagnosis.

Formulating a Treatment Plan. (1) The physician shall formulate and document in the patient’s medical record the proposed treatment plan, based upon the working diagnosis of the medical complaint and related symptoms, along with relevant baseline information obtained in the evaluation of the patient;

(2) The treatment plan shall include specific and verifiable goals of treatment, with a schedule for periodic evaluations, which will permit the physician to assess whether a treatment is appropriately addressing the medical complaint and improving the patient’s functional abilities. Statements such as “treat a medical condition and related symptoms”, “the patient feel better,” or “prescribe controlled substances” are not sufficient treatment goals. The treatment plan shall include an exit strategy for the termination of use of any treatment modality, including controlled substance, for appropriate reasons;

Patient Screening. (1) The physician shall utilize appropriate screening tools to screen each patient to determine if the patient:

(a) Is presently suffering from abuse or dependence of any substance, including alcohol;
(b) Is presently suffering from a psychiatric or psychological condition that requires treatment or that may impact the patient’s treatment with controlled substances; or
(c) Presents a significant risk for illegal diversion of controlled substances from multiple practitioners or has refilled prescriptions for controlled substances inappropriately.

(2) If, after screening, the physician determines that there is a reasonable likelihood that the patient suffers from substance abuse or dependence, the physician shall refer the patient to an appropriate treatment program or provider, or to an addiction specialist. If, after screening, the physician determines that there is a reasonable likelihood that the patient suffers from a qualifying psychiatric or psychological condition, the physician shall refer the patient for a psychological or psychiatric consultation, if appropriate. After making such referral, the physician shall consider the recommendations of the treatment program or specialist before determining whether to continue with the long-term use of controlled substances with that patient, and if so, appropriate treatment measures and monitoring. The physician shall document all relevant information about the screen, the referral, the recommendations, and any resulting prescribing decisions in the patient’s medical record;

(3) If, after screening, the physician determines that there is a significant likelihood that the patient may illegally divert controlled substances, the physician must determine whether the use of a “prescribing agreement” would be sufficient to prevent diversion. This determination necessarily requires the physician to determine whether they have the professional resources to effectively monitor the patient’s controlled substance use. The terms of a “prescribing agreement” shall include, but not be limited to the patient’s agreement to:

(a) Avoid improper use of controlled substances;
(b) Identify other licensed professionals providing medical care to the patient and authorize the physician to communicate with these other providers to coordinate care, particularly prescribing or dispensing of controlled substances;
(c) Only obtain controlled substances from the designated pharmacy;
(d) Only fill controlled substances prescriptions at an approved pharmacy;
(e) Submit to urine drug screens or pill counts on request;
(f) Not seek early refills or call-in prescriptions of controlled substances;
(g) To produce an official police report for any effort to replace controlled substances that were lost or stolen;
(h) If necessary, submit to third-party administration of controlled substances prescribed if determined appropriate. In order to avoid confusion and for the benefit of both parties, the physician shall consider including in the agreement the consequences for a violation of each provision. The “prescribing agreement” and informed consent document may be combined into one document;

(4) The physician shall obtain and document a baseline urine drug screen to determine whether the medications that are being prescribed are in the patient’s system and to determine whether any un-prescribed or illegal controlled substances are in the patient’s system.

If, after screening, the physician determines that the controlled substances prescribed to the patient will be used or are likely to be used other than medicinally or other than for an accepted therapeutic purpose, the physician shall not prescribe controlled substances to that patient;

Obtaining Informed Consent. (1) The physician shall explain the risks and benefits of long-term use of controlled substances and obtain informed consent from the patient for such prescribing. The controlled substances to a patient on a long-term basis should be a deliberate and conscious decision by both the physician and the patient, after full consideration of the risks and benefits of such treatment;

(2) After explaining the risks and benefits of long-term use of controlled substances, the physician shall obtain the informed consent of the patient, in a writing that specifically sets out each risk and benefit discussed with the patient, and shall include and maintain that written informed consent in the patient’s medical record. The informed consent document and any “prescribing agreement” may be combined into one document.

Initial Trial of Other Treatments: Titration. (1) Controlled substances shall only be utilized on a long-term basis after other appropriate therapies have been attempted and have proven unsuccessful in appropriately treating the medical complaint and related symptoms. If controlled substances are utilized on a long-term basis, the physician shall prescribe or dispense controlled substances at the lowest level and for the shortest duration necessary to appropriately treat the medical complaint and related symptoms;

(2) The physician shall initially attempt, to the extent possible, or to establish and document a previous attempt by another physician, in increasing order, the following steps to treat the medical complaint and related symptoms:

(a) Use of physical therapy modalities alone or use of non-steroidal anti-inflammatory medication alone;
(b) Use of physical therapy modalities in conjunction with non-steroidal anti-inflammatory medication;
(c) Use of lowest level of controlled substances considered effective to treat the medical complaint and related symptoms, as part of an opioid trial; and,
(d) Titration of levels of controlled substances in measured steps until the level of controlled substances adequately treats the medical complaint and related symptoms.

Section 4. Professional Standards for Long-Term Prescribing or Dispensing of Controlled Substances. If a physician continues to prescribe or dispense controlled substances beyond three (3) months for a specific medical complaint and related symptoms, the physician shall comply with the follow-
Reviewing Functional Goals; Specialty Consultations. (1) The physician shall review and determine whether the patient is exhibiting improved function, by meeting treatment goals as jointly determined, and is responding favorably to the medical treatment, including controlled substance therapy; (2) For patients presenting a significant risk of diversion or improper use of controlled substances, the physician shall obtain the patient's consent to discuss the patient's treatment with independent sources, including family members, in order to verify: (a) The patient's progress toward or achievement of treatment goals; and, (b) The patient's use of controlled substances and any side effects of that use, through independent sources; (3) If the medical complaint and related symptoms continue with no significant improvement in function despite treatment with controlled substances, the physician shall obtain consultative assistance to determine whether there are undiagnosed and undiagnosable controlled substances, such as psychiatry, psychology, internal medicine, physical medicine and rehabilitation, orthopedics, addiction medicine, rheumatology, or oncology; (4) For patients exhibiting symptoms suggestive of mood, anxiety and/or psychotic disorders, the physician shall obtain psychiatric or psychological consultations for intervention if such condition is affecting treatment.

Managing Breakthrough Pain. (1) If a patient reports that they are experiencing episodes of "breakthrough" pain, the physician shall: (a) Attempt to identify the trigger or triggers for such episodes; (b) Determine whether the breakthrough pain may be adequately treated through non-controlled treatment; (c) If the episodes continue and the non-medication treatments do not adequately address the triggers, and after considering the risks and benefits, the physician determines to add an as-needed controlled substance to the regimen, the physician must take appropriate steps to minimize the improper or illegal use of the additional controlled substances by prescribing or dispensing only the amount of controlled substances needed to treat the specific medical complaint, for a definite, pre-determined time period. The physician shall also include appropriate monitoring of the additional controlled substance;

Preventive Medicine. (1) At least once a year, the physician shall perform or shall ensure that the patient's primary treating physician performs preventive health screening and physical examination appropriate to the patient's gender, age, and medical condition. The physician shall ensure that the patient is provided a written summary or order to obtain the findings and results of such screening. The physician shall document in the patient's medical record the annual preventive health screening performed or the results of the screening performed by the primary treating physician, the findings and results, and the treatment provided, if any; Periodic KASPER Reviews and Monitoring Adherence. (1) At least once every three months, the physician shall obtain and review a current KASPER report to ensure that the patient is properly filling the prescriptions issued and that the patient is not obtaining controlled substances from other practitioners without the physician's knowledge and approval; (2) If, at any time while the physician is prescribing or dispensing controlled substances to a patient, the physician obtains or receives specific information that the patient is not taking the controlled substances as directed, is diverting controlled substances, or is engaged in any improper or illegal use of controlled substances, the physician shall immediately obtain and review a KASPER report for the purposes specified in subsection (1), supra; (3) If a KASPER report discloses that the patient is not filling or obtaining controlled substance prescriptions as directed or is obtaining controlled substances from other practitioners without the physician's knowledge and approval, the physician shall immediately address these issues with the patient. The physician shall not prescribe or dispense any more controlled substances, unless the physician has addressed the issues with the patient and has determined that it is medically appropriate and is not obtaining controlled substances to the patient; (4) If a KASPER report discloses that the physician is obtaining controlled substances from other practitioners without the physician's knowledge and approval, the physician shall promptly notify the appropriate law enforcement agency and the other practitioners of the relevant information from the KASPER review; (5) The physician shall document in the patient's medical record each time a KASPER review is performed, information obtained, and, if applicable, the patient's account of any irregularities noted in the review; and, the physician's determination of what actually occurred; (6) If the physician should determine that it is medically appropriate and safe to continue or resume prescribing or dispensing controlled substances, the physician shall taper their use to their previously prescribed quantities to allow the patient to gradually decrease the use of the controlled substances; (7) The physician shall fully document in the patient's medical record the physician's rationale for resuming such prescribing or dispensing controlled substances to the patient;

Random Pill Counts. (1) When appropriate, the physician shall conduct unannounced random pill counts to determine whether the patient is taking the controlled substances as directed; (2) If the physician discovers irregularity in the pill count, the physician shall immediately address those findings with the patient. The physician must use all available information, including a discussion with the patient, to determine whether the patient is illegally diverting controlled substances; if at least once since the pill count, the physician determines that the patient has diverted controlled substances, the physician should immediately discontinue the prescribing or dispensing of controlled substances to that patient, if medically feasible. If it is not medically feasible to immediately discontinue the prescribing or dispensing of controlled substances, the physician shall...
immediately begin a tapering process to safely discontinue prescribing or dispensing controlled substances, after putting in place specific protections that will ensure that no further diversion occurs, such as requiring storage and administration of the controlled substances to the patient by a person designated by the physician, with additional random pill counts;

(4) The physician shall fully document the results of each pill count conducted, the physician’s determination of the reasons for any shortage, and the physician’s decisions regarding continued treatment in the patient’s medical record.

Urine Drug Screenings. (1) During the course of long-term prescribing or dispensing of controlled substances, the physician shall utilize urine drug screens in a random manner at appropriate times to determine whether the patient is taking prescribed medications or taking illegal substances or medications not prescribed by the physician.

(2) If the patient tested negative for controlled substances prescribed or dispensed by the physician and confirmatory testing substantiates a “red flag,” the physician shall do one of the following:

(a) Do a controlled taper;
(b) Stop prescribing or dispensing controlled substances immediately; or,
(c) Refer the patient to an addiction specialist or drug treatment program, depending upon the circumstances.

(3) The physician shall discontinue controlled substance treatment and/or refer the patient to addiction management if one or more of the following conditions exist:

(a) There has been no improvement in function and response to the medical complaint and related symptoms;
(b) Controlled substance therapy has produced significant adverse effects or diversion;
(c) The patient exhibits drug-seeking behavior or diversion.

Section 5. Professional Standards for Prescribing or Dispensing Controlled Substances in an Emergency Department Setting. The following professional standards apply to physicians who prescribe or dispense controlled substances in an emergency department setting.

(1) Before prescribing or dispensing a controlled substance in an emergency department setting, the physician shall:

(a) Obtain an appropriate medical history relevant to the medical complaint and conduct a physical examination of the patient relevant to the medical complaint and related symptoms, and document the information in the patient’s medical record;
(b) Obtain and review a KASPER report for all available data on the patient, document relevant information in the patient’s record, and consider the available information to determine whether it is medically appropriate and safe to prescribe or dispense controlled substances. If the physician cannot obtain a KASPER report for review in sufficient time to make the determination whether to prescribe or dispense controlled substances, the physician shall not prescribe or dispense controlled substances unless demonstrated and documented in the patient’s medical record that the medical necessity for, and safety in prescribing or dispensing the controlled substance substantially outweigh the risk of unlawful use or diversion of the controlled substances, particularly considering the nature and severity of the patient’s presenting complaint;
(c) After examining the benefits and risks of prescribing or dispensing controlled substances to the patient, including non-treatment or other treatment, make a deliberate decision that it is medically appropriate to prescribe or dispense the controlled substances, and, if appropriate, document that decision in the patient’s record and, if appropriate, the reasoning underlying that decision.

(2) The physician is strongly discouraged from and shall not routinely:

(a) Administer intravenous and/or intramuscular controlled substances for the relief of acute exacerbations of chronic pain;
(b) If the physician determines that exceptional circumstances exist which warrant prescribing or dispensing controlled substances in a manner that is strongly discouraged in Section 7(1), supra, the physician shall document in the patient’s medical record the exceptional circumstances that warranted such prescribing or dispensing,
(c) The physician shall ensure that each patient receiving controlled substances by dispensing or prescription is given informed, by handout or display signage, of the standards established in this regulation regarding the prescribing or dispensing of controlled substances.

(3) These standards shall not apply or be enforced during periods involving disaster, mass casualties, or extreme emergency.

Section 6. Professional Standards for Documentation of Patient Assessment, Education, Treatment Agreement and Informed Consent, Action Plan, Outcomes and Monitoring. (1) Each physician shall document all relevant information in a patient’s medical record in a legible manner and in sufficient detail to provide for:

(a) Meaningful diagnosis and treatment of the patient;
(b) The safe and medically appropriate assumption of care by another physician at any given time; and,
(c) This board to determine whether the physician is conforming to professional standards for prescribing or dispensing controlled substances and other relevant professional standards. Such information includes, but is not limited to:

(a) Medical history and physical examination;
(b) Diagnostic and laboratory test results and therapeutic outcomes;
(c) Evaluations and consultations;
(d) Records of past treatment outcomes including indicators of benefits, such as functional outcomes, and indicators of risk, such as adverse effects;
(e) Medications (including date prescribed, type, dosage, and strength and quantity);
(f) Intensity levels of medical complaint and related symptoms;
(g) Subjective complaints of the patient;
(h) Objective findings related to subjective complaints, including impact on functioning and quality of life;
(i) Diagnostic impressions, and potential treatment options;
(j) Treatment objectives;
(k) Discussion of risks and benefits;
(l) Informed consent;
(m) Instructions and agreements; and
(n) Periodic review of treatments, including adverse effects, functional goals, and any other outcomes that reflect benefits or problems with the treatment.

(2) If a physician is unable to conform to professional standards for prescribing or dispensing controlled substances to the professional standards established by KRS 218A.172, or to other professional standards, due to circumstances beyond their control, the physician shall appropriately document in the patient’s record the physician’s response to the inability to conform to the specific standards and the impact upon the continuing care of the patient.

Section 7. Responsibility to Educate Patients Regarding the Dangers of Controlled Substance Use. (1) It is the accept-
able and prevailing medical practice within the Commonwealth of Kentucky for physicians prescribing or dispensing controlled substances to educate patients receiving controlled substances about the following subjects through verbal or written counseling:

(a) Proper use;
(b) Impact upon driving and work safety;
(c) Effect of use during pregnancy;
(d) Potential for overdose and appropriate response to overdose;
(e) Safe storage of controlled substances;
(f) Proper disposal;
(2) Educational materials relating to these subjects may be found on the board’s Web site, www.kbml.ky.gov, and are incorporated by reference into this provision.

Section 8. Violations. (1) Any violation of the professional standards established in this regulation or in KRS 218A.172 shall constitute a violation of KRS 311.595(12) and (9), which may result in the imposition of disciplinary sanctions pursuant to KRS 311.596;
(2) Each violation of the professional standards established in this regulation or in KRS 218A.172 shall be established by expert testimony by one or more physicians retained by the board, following a review of the licensee’s patient records and other available information including KASPER reports.

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: July 20, 2012
FILLED WITH LRC: July 20, 2012 at 2 p.m.
CONTACT PERSON: C. Lloyd Vest II, General Counsel, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; phone (502) 429-7150, fax (502) 429-7118.

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(As Amended at ARRS, January 7, 2013)


STATUTORY AUTHORITY: KRS 311.565(1)(a), (b), 311.601(1), (2)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.601(1) authorizes the board to promulgate an administrative regulation that establishes requirements to ensure the continuing professional competency of licensees. [The amendment affected in this administrative regulation is established medical education requirements for physicians in Kentucky, including requirements for courses relating to the use of KASPER, pain management, and addiction disorders required for physicians who prescribe or dispense controlled substances in the Commonwealth of Kentucky.

Section 1. Continuing Medical Education. Except as provided in Section 4 of this administrative regulation, at the time a licensee seeks to renew his or her license, the licensee shall submit [with his annual license renewal form] verification of satisfactory completion of a program of continuing medical education using the Continuing Medical Education Certification Form by the renewal deadline established in 201 KAR 9:051.

Section 2. In order to meet the continuing medical education requirements, a licensee shall:

(1) Submit evidence that thirty (30) of the sixty (60) hours were [shall have been] certified in Category I by an organization accredited by the:
(a) Accreditation Council on Continuing Medical Education; or
(b) The American Osteopathic Association;
(2) [ ] Submit evidence that:
(a) The licensee has received the American Medical Association’s “physician recognition award”, or the American Osteopathic Association’s “osteopathic physicians’ recognition award”; and
(b) The award is in effect at the time the [ ] license is renewed;
(3) Submit verification that the:
(a) Licensee has completed continuing medical education requirements of any specialty organization which is recognized by the American Medical Association or American Osteopathic Association[AMA or AOA] as at least equivalent to their recognition awards; and
(b) Certification is in effect at the time a license is renewed; or
(c) Submit verification that the licensee is in, or has been in, an approved postgraduate training program. [66] Each year of postgraduate training shall be equivalent to fifty (50) hours of continuing medical education.

Section 3. Required Hours of Continuing Education. (1) [ ] For each three (3) year continuing education cycle, a licensee shall complete:
(a) a total of sixty (60) hours of continuing medical education, if his or her license has been renewed for each year of a continuing medical education cycle.
(b) If the [ ] license has not been renewed for each year of a continuing medical education cycle, a licensee shall complete twenty (20) hours of continuing medical education for each year for which the [ ] license has been renewed.
(c) A licensee whose initial licensure was granted the first year of the continuing education cycle for which verification is submitted shall complete sixty (60) hours of continuing medical education before the end of the cycle;
(d) A licensee whose initial licensure was granted the second year of the continuing education cycle for which verification is submitted shall complete forty (40) hours of continuing medical education before the end of the cycle;
(e) A licensee whose initial licensure was granted the third year of the continuing education cycle for which verification is submitted shall complete twenty (20) hours of continuing medical education before the end of the cycle.
(2) Upon renewal of licensure following the end of a three (3) year continuing education cycle, a licensee shall certify that he or she has met the continuing medical education requirements for the cycle as provided by this section.
(3) Verification of completion of continuing medical education requirements shall be submitted upon request by the board.

Section 4. Extensions of Time. (1) To request an extension of time, the licensee shall submit
(a) A completed Request for Extension to Complete Required CME Hours; and
(b) The fee required by 201 KAR 9:041, Section 1(17).
(2) The board may grant an extension of time to a physician who for sufficient cause has not yet received continuing medical education certification following the submission of the items required by subsection (1) of this section.

Section 5. During each ten (10) year period of [ ] practice, each licensee shall complete a minimum of two (2) hours of continuing medical education in HIV/AIDS courses approved pursuant to KRS 214.610, 214.615 and 214.620.

Section 6. (1) For each three (3) year continuing education cycle beginning on January 1, 2013, a licensee who is authorized to prescribe or dispense controlled substances within the Commonwealth at any time during that cycle shall complete at least four and one-half (4.5) hours of approved continuing education hours relating to the use of KASPER, pain management, addiction disorders, or a combination of two (2) or more of those subjects. A licensee may satisfy this requirement by completing a single approved program of four and one-half (4.5) hours or longer or by completing multiple approved programs for a total of four and one-half (4.5) hours or longer for that cycle.
(2) Each physician licensed to practice medicine or osteopathy within the Commonwealth of Kentucky who is authorized to prescribe or dispense controlled substances within the Common-
wealth from July 20, 2012 through the end during any portion of the three (3) year continuing education cycle beginning on January 1, 2012 and ending on December 31, 2014 shall complete at least four and one-half (4.5) hours of approved Category I Credit continuing medical education hours relating to the use of KASPER, pain management, addiction disorders, or a combination of two (2) or more of those subjects on or before December 31, 2014. The licensee may satisfy this requirement by completing a single approved program of four and one-half (4.5) hours or longer or by completing multiple approved programs for a total of four and one-half (4.5) hours or longer for this cycle.

(2) Each physician licensed to practice medicine or osteopathy within the Commonwealth of Kentucky who is authorized to prescribe or dispense controlled substances during the calendar years 2013 and 2014, but not during any portion of 2012, shall complete at least three (3) hours of approved Category I Credit continuing medical education during any portion of calendar year 2014 shall complete at least one and one-half (1.5) hours of approved continuing education hours relating to the use of KASPER, pain management, addiction disorders, or a combination of two (2) or more of those subjects on or before December 31, 2014. The licensee may satisfy this requirement by completing a single approved program of three (3) hours or longer or by completing multiple approved programs for a total of three (3) hours or longer for those two (2) years.

(3) Each physician licensed to practice medicine or osteopathy within the Commonwealth of Kentucky who is authorized to prescribe or dispense controlled substances during calendar year 2014, but not during any portion of 2012 or 2013, shall complete at least one and one-half (1.5) hours of approved Category I Credit continuing medical education hours relating to the use of KASPER, pain management, addiction disorders, or a combination of two (2) or more of those subjects on or before December 31, 2014. The licensee may satisfy this requirement by completing a single approved program of one and one-half (1.5) hours or longer or by completing multiple approved programs for a total of one and one-half (1.5) hours or longer for that calendar year, and shall submit written verification of compliance to the board on or before January 15, 2015.

(5)(4)[a] To qualify as approved continuing education under this section, the educational program shall[must] have been approved in advance for the specified number of continuing education hours by the board.

(b) The board may approve an educational program[programs] that:

1. Consist[consists] of a live presentation;
2. Is[are] presented by a live or recorded webinar[webinars]; or
3. Is[are] presented through an online module[modules].

(c) The board shall maintain a current listing of approved continuing education programs on its official Web site. [-] www.kbmi.ky.gov.

(6)(5)[a] In order to lawfully prescribe or dispense controlled substances within the Commonwealth of Kentucky, a licensee shall[must] complete the required number of continuing education hours for each period designated in this section.

(b) Failure to complete the required number of continuing education hours for the required period[,] or to submit the required written verification within the time specified shall constitute a violation of KRS 311.595(9) and (12), which shall constitute an immediate danger to the public health, safety, or welfare, for the purposes of KRS 311.592 and 13B.125.

(c) If the board determines that a licensee has failed to complete the required continuing education hours within the time specified or has failed to provide the written verification of completion within the time specified, the appropriate inquiry panel or its chair shall promptly issue an emergency order restricting that licensee from prescribing or dispensing controlled substances within the Commonwealth of Kentucky until [such time as] the licensee has completed the required continuing education hours for that period and has provided written verification of [such] completion to the board.

(d) An emergency order restricting a licensee from prescribing or dispensing controlled substances within the Commonwealth of Kentucky issued pursuant to paragraph (c) of this subsection shall remain valid and in effect until the board has received written verification that the licensee has successfully completed the required continuing education hours for the time period specified. Upon receipt of the such written verification, the panel or its chair shall immediately issue an order terminating the emergency order issued pursuant to this section.

(e) If a licensee who is affected by an emergency order issued pursuant to this section requests an emergency hearing pursuant to KRS 13B.125(3), the hearing officer conducting the emergency hearing shall affirm the emergency order if presented with written notification on board letterhead stating that the board has not received the required written verification that the licensee completed the required continuing education hours for the period specified by the time specified.

(7)[(b)] If a licensee prescribes or dispenses a[s] should prescribe or dispense controlled substances within the Commonwealth of Kentucky during any period after the licensee has failed to complete the required continuing education hours within the time specified or has failed to provide written verification of [such] completion within the time specified, each instance of prescribing or dispensing of a[s] controlled substances shall constitute a separate violation of KRS 311.595(2) and (9), as illustrated by KRS 311.597(1)(b) and shall[will] serve as the basis for disciplinary sanctions pursuant to KRS 311.595.

Section 7. The board may randomly require physicians submitting certification of continuing medical education to demonstrate satisfactory completion of the continuing medical education requirements stated in the[his] certification.

Section 8.[Z] (1) A licensee shall be fined a minimum of $200 [dollars], if he or she fails to:

(a) Timely complete the continuing medical education requirements; or
(b) Obtain an extension of time for completion of the continuing medical education requirements.

(2)[a] A licensee subject to subsection (1) of this section shall be immediately suspended when a period of six (6) months comes into compliance.

(b) If a licensee has not completed the continuing medical education requirements within the six (6) month period established by this subsection, his or her license shall:

1. Be immediately suspended; and
2. Remain suspended until the licensee[has] has submitted verifiable evidence that he or she has completed the continuing education requirements.

Section 9. [8] A waiver of the requirements established by the provisions of this administrative regulation shall not be granted.

Section 10.[9] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Continuing Medical Education Certification Form", January 2013; and

(b) "Request for Extension to Complete Required CME Hours", January 2013; and

2. This material[form] may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, 8 a.m. to 4:30 p.m., Monday through Friday.

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: July 20, 2012
FILED WITH LRC: July 20, 2012 at 2 p.m.
CONTACT PERSON: C. Lloyd Vest II, General Counsel, Ken- tucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, phone (502) 429-7150, fax (502) 429-7118.
GENERAL GOVERNMENT CABINET
Board of Speech-Language Pathology and Audiology
(As Amended at ARRS, January 7, 2013)

201 KAR 17:090. Continuing education requirements.

RELATES TO: KRS 334A.170(4)
STATUTORY AUTHORITY: KRS 334A.080(3), 334A.170(4)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 334A.080(3) requires the Board of Speech-Language Pathology and Audiology to promulgate responsible administrative regulations, including administrative regulations which delineate qualifications for licensure and renewal of licensure. KRS 334A.170(4) requires the board to promulgate administrative regulations to set forth requirements concerning continuing professional education. This administrative regulation establishes the requirements for continuing education and prescribes methods and standards for the accreditation of continuing education courses.

Section 1. Definitions. (1) "Academic courses offered by an accredited postsecondary institution" means:
(a) A speech-language pathology or audiology course, designated by a speech-language pathology or audiology title or content; or
(b) An academic course, relevant to speech-language pathology or audiology.
(2) "Approved" means recognized by the Kentucky Board of Speech-Language Pathology and Audiology.
(3) "Continuing education hour" means sixty (60) clock minutes of participating in continuing educational experiences.
(4) "Program" means an organized learning experience:
(a) Planned and evaluated to meet behavioral objectives; and
(b) Presented in one (1) session or a series.
(5) "Provider" means an organization approved by the Kentucky Board of Speech-Language Pathology and Audiology for providing a continuing education program.
(6) "Related" means having content that is not directly linked to the practice of speech-language pathology or audiology, but expands or augments clinical practice.
(7) "Relevant" means having content applicable to the practice of speech-language pathology or audiology.

Section 2. Accrual of Continuing Education Hours. (1) A minimum of thirty (30) continuing education hours shall be accrued by each person holding licensure as a speech-language pathologist, speech-language pathology assistant, or audiologist during the biennial period for renewal. [Effective February 1, 2013.] Two (2) of these hours shall be focused on ethics.
(2) A person who holds a license in both speech-language pathology and audiology shall complete a minimum of fifty (50) continuing education hours during the biennial period for renewal. This person shall obtain continuing education hours in both areas of licensure. [Effective February 1, 2013.] Two (2) of these hours shall be focused on ethics.
(3) All continuing education hours shall be in the field in which the person is licensed. The licensee may use up to a maximum of four (4) hours in a related area for each biennial period.
(4) A person newly licensed during the license renewal period shall not be required to complete continuing education as a prerequisite for the first renewal of his license.
(5) A person failing to renew the license within the five (5) year period after its expiration shall obtain a license only after meeting the initial licensure requirements of 201 KAR Chapter 17. In addition, the applicant shall provide proof of the successful completion of thirty (30) hours of continuing education within the last two (2) years for a speech-language pathology, speech-language pathology assistant, or audiology license or fifty (50) hours of continuing education for a license in both speech-language pathology and audiology.
(6) Continuing education shall be completed by January 31 of the renewal period.

Section 3. Methods of Acquiring Continuing Education Hours. Continuing education hours applicable to the renewal of the license shall be directly related to the professional growth and development of a speech-language pathologist, speech-language pathology assistant, or audiologist. (1) The hours shall be earned by completing any of the following educational activities:
(a) Programs not requiring board review and approval. An educational program from any of the following providers shall be deemed to be relevant to the practice of speech-language pathology or audiology and shall be approved without further review by the board if the program is:
1. Sponsored or approved by:
   a. The American Speech-Language-Hearing Association; or
   b. The American Academy of Audiology; or
2. An academic course offered by an accredited postsecondary institution directly related to speech-language pathology or audiology. Academic credit equivalency for continuing education hours shall be based on one (1) credit hour equals fifteen (15) continuing education hours. Programs designated to meet degree requirements shall not be acceptable.
(b) Programs requiring board review and approval. The board shall issue an approval number upon receipt of the documentation required by Section 4 of this administrative regulation. A program from any of the following sources shall be reviewed and determined if the program is relevant and therefore subsequently approved by the board:
1. A program, including a home study course or in-service training provided by another organization, educational institution, or service provider approved by the board in accordance with Section 5 of this administrative regulation;
2. A program or academic course presented by the licensee. A presenter of a relevant program or academic course shall earn full continuing education credit for each contact hour of instruction, not to exceed one-half (1/2) of the continuing education renewal requirements. Credit shall not be issued for repeated instruction of the same course; or
3. Authoring an article in a relevant, professionally recognized or juried publication. Credit shall not be granted for an article unless the article was published within the two (2) year period immediately preceding the renewal date and a licensee shall not earn more than one-half (1/2) of the continuing education hours required for renewal. More than one (1) publication shall not be counted during a renewal period.
4. Online coursework shall not exceed ten (10) hours per day.
   (2) A general education course, elective course, or a course designated to meet degree requirements shall not be acceptable.
(3) Related continuing education subjects which are not specifically a part of the field of speech-language pathology or audiology may be approved for up to four (4) continuing education hours if the board believes that the related areas serve to enhance the licensee's ability to practice. The four (4) hour maximum credit for related areas of study by the licensee shall be applicable to only one (1) license (speech-language pathology or audiology) for those individuals who hold dual licensure.

Section 4. Procedures for Approval of Continuing Education Programs. A course, which has not been preapproved by the board, may be used for continuing education if approval is secured from the board for the course. The board may consider for approval a Continuing Education program if one (1) or more of the following items have been submitted. In order for the board to adequately review a program, the following information shall be submitted:
(a) A published course or seminar description;
(b) Names and qualifications of the instructors;
(c) A copy of the program agenda indicating hours of education, coffee and lunch breaks;
(d) Number of continuing education hours requested;
(e) Application to the board for continuing education credits approval.

Section 5. Procedures for Preapproval of Continuing Education Sponsors and Programs. (1) Sponsor approval. An entity seeking to obtain approval:
(a) Of a continuing education program prior to its offering shall apply to the board at least thirty (30) days in advance of the commencement of the program, and shall provide the information re-
required in Section 4 of this administrative regulation; or
(b) As a prior-authorized continuing education provider under
Section 3(1)(a) of this administrative regulation shall satisfy the
board that the entity seeking this status:
1. Consistently offers programs which meet or exceed all the
requirements set forth in subsection (2) of this section; and
2. Does not exclude a licensee from its programs.
(2) A continuing education activity shall be qualified for ap-
proval if the board determines the activity being presented:
(a) Is an organized program of learning;
(b) Pertains to subject matters which integrally relate to the
practice of speech-language pathology or audiology;
(c) Contributes to the professional competency of the licensee;
and
(d) Is conducted by individuals who have relevant educational
training or experience.
(3) Providers of continuing education shall provide attendees
with a certificate of completion including the course approval num-
ber provided by the board.

Section 6. Responsibilities and Reporting Requirements of a
Licensee. (1) During the licensure renewal period, up to fifteen (15)
percent of all licensees shall be selected at random by the board
and required to furnish documentation of the completion of the
appropriate number of continuing education hours. Verification of
continuing education hours shall not otherwise be reported to the
board:
(2) A licensee shall:
(a) Be responsible for obtaining required continuing education
hours;
(b) Identify his own continuing education needs and seek activ-
ities that meet those needs;
(c) Seek ways to integrate new knowledge, skills and attitudes;
(d) Select approved activities by which to earn continuing edu-
cation hours;
(e) Submit to the board, if applicable, a request for approval for
continuing education activities not approved as required in Section
3(1) of this administrative regulation;
(f) At the time of renewal, list the continuing education hours
obtained during that licensure renewal period;
(g) Document attendance, participation in, and successful
completion of continuing education activity for a period of two (2)
years from the date of the renewal; and
(h) Maintain records of continuing education hours.
(3) If audited, the following items are required to document
continuing education activity:
(a) A transcript or tracking sheet issued by a professional asso-
ciation; or
(b) A transcript, official certificate of completion, or affidavit
signed by the instructor;
(4) Failure to comply with the provisions of this administrative
regulation shall constitute a violation of KRS 334A.170(4) and shall
result in:
(a) Refusal to renew licensure;
(b) Suspension of licensure; or
(c) Revocation of licensure;
(5) Documentation sent to the board prior to renewal shall be
returned to the licensee by regular mail.

Section 7. Responsibilities and Reporting Requirements of
Providers and Sponsors. (1) A provider of continuing education not
requiring board approval shall be responsible for providing docu-
mentation, as established in Section 5(2) of this administrative regu-
lation, directly to the licensee.
(2) A sponsor of continuing education requiring board approval
shall be responsible for submitting a course offering to the board
for review and approval before listing or advertising that offering as
approved by the board. The board shall provide an identifying
number for the sponsor to use in identifying the course.

Section 8. Board to Approve Continuing Education Hours;
Appeal of Denial. (1) If an application for approval of continuing
education hours is denied, in whole or part, the licensee shall have
the right to appeal the board's decision.
(2) An appeal shall be:
(a) In writing;
(b) Received by the board within thirty (30) days after the date
of the decision denying approval of continuing education hours; and
(c) Conducted in accordance with KRS Chapter 13B.

Section 9. Waiver or Extensions of Continuing Education. (1)
On application, the board may grant a waiver of the continuing
education requirements or an extension of time within which to
fulfill the requirements in the following cases:
(a) Medical disability of the licensee;
(b) Illness of the licensee or an immediate family member; or
(c) Death or serious injury of an immediate family member.
(2) A written request for waiver or extension of time involving
medical disability or illness shall be:
(a) Submitted by the person holding licensure; and
(b) Accompanied by a verifying document signed by a licensed
professional.
(3) A waiver of or extension of time within which to fulfill
the minimum continuing education requirements shall not exceed one
(1) year.

Section 10. Continuing Education Requirements for a Person
on Inactive Status or Holding Interim Licensure. (1) Except as provided by subsection (3) of this section, the continuing edu-
cation hours shall be at least one hundred (100) approved hours.
(2) A person seeking reinstatement or reactivation of licensure shall submit evidence of
1. Consistently offers programs which meet or exceed all the
requirements established in Section 2 of this administrative
regulation shall be approved by the board. The board shall provide an i
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(a) Submitted by the person holding licensure; and
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(2) An appeal shall be:
(a) In writing;
(b) Received by the board within thirty (30) days after the date
of the decision denying approval of continuing education hours; and
(c) Conducted in accordance with KRS Chapter 13B.
Section 1. Definitions. (1) "Client" means [as defined as] the person receiving the services of the speech-language pathologist and audiologist and the representative thereof if required by law; (2) "Telehealth" means by KRS 334A.200(3); (3) "Telepractice" means the practice of speech language pathology or audiology as defined by KRS 334A.020(4) and KRS 334.020(6) respectively provided by using communication technology that is two (2) way, interactive, and simultaneous [ly] audio and video.; (a) Provided using an electronic communication technology; or (b) Two (2) way, interactive, simultaneous audio and video.]

Section 2. Client Requirements. A practitioner-patient relationship shall not commence via telehealth. An initial, in-person meeting for the practitioner and patient who prospectively utilize telehealth shall occur. A licensed health care practitioner may represent the licensee at the initial, in-person meeting. A licensee who uses telehealth to deliver speech language pathology or audiology services or who telepractices or the licensed health care practitioner representing the licensee shall, at the initial, in-person meeting with the client: (1) Make reasonable attempts to verify the identity of the client; (2) Obtain alternative means of contacting the client other than electronically; (3) Provide to the client alternative means of contacting the licensee other than electronically; (4) Document if the client has the necessary knowledge and skills to benefit from the type of telepractice provided by the licensee; and (5) Inform the client in writing about: (a) The limitations of using technology in the provision of telepractice; (b) Potential risks to confidentiality of information due to technology in the provision of telepractice; (c) Potential risks of disruption in the use of telepractice; (d) When and how the licensee will respond to routine electronic messages; (e) In what circumstances the licensee will use alternative communications for emergency purposes; (f) Who else may have access to client communications with the licensee; (g) How communications can be directed to a specific licensee; (h) How the licensee stores electronic communications from the client; and (i) That the licensee may elect to discontinue the provision of services through telehealth.

Section 3. Competence, Limits on Practice, Maintenance, and Retention of Records. A licensee using telehealth to deliver services or who telepractices shall: (1) Limit the telepractice to the licensee's scope of practice to the area of competence in which proficiency has been gained through education, training, and experience; and (2) Maintain continuing [current] competency or associate with a group who has experience in telehealth delivery of care in telepractice through continuing education, consultation, or other procedures, in conformance with current standards of scientific and professional knowledge; (3) Document the client's presenting problem, purpose, or diagnosis; (4) Use methods for protecting health information which shall include authentication and encryption technology; (5) Limit access to that information to only those necessary for the provision of services or those required by law; (6) Use secure communications with clients, including encrypted text messages, via e-mail or secure Web sites, and not use personal identifying information in non-secure communications; and (5) Ensure that confidential communications obtained and stored electronically cannot be recovered and accessed by unauthorized persons when the licensee disposes of electronic equipment and data.

Section 4. Compliance with Federal, State, and Local Law. (1) A licensee using telehealth to deliver speech language pathology and audiology services and telepractice shall comply with: (a) State law by being licensed to practice speech language pathology or audiology, whichever is being telepracticed, in the jurisdiction where the practitioner-patient relationship commenced; and (b) Section 508 of the Rehabilitation Act, 29 U.S.C. 794(d), to make technology accessible to a client with disabilities; (2) If a person provides speech language pathology and audiology services via telepractice to a person physically located in Kentucky at the time the services are provided, that provider shall be licensed by the board. (3) A person providing speech language pathology and audiology services via telepractice from a physical location in Kentucky shall be licensed by the board. This person may be subject to licensure requirements in other states where the services are received by the client.

Section 5. Representation of Services and Code of Conduct. A licensee using telehealth to deliver services or who telepractices: (1) Shall not engage in false, misleading, or deceptive advertising of telepractice; and (2) Shall not split fees.

ANNE OLSON, Board Chair
APPROVED BY AGENCY: December 12, 2012
FILED WITH LRC: December 13, 2012 at noon
CONTACT PERSON: Marcia Egbert, Board Administrator, Kentucky Board of Speech Language Pathology and Audiology, PO Box 1370, Frankfort, Kentucky 40602.
Section 3. Approved Programs. (1) A baccalaureate degree from a college of arts and sciences approved by the board pursuant to KRS 310.021(3) or 310.031(2)(a) shall be a degree program that is listed as accredited by the Commission on Accreditation for Dietetics Education.

(2) If an applicant's baccalaureate degree is not listed as accredited by the Commission on Accreditation for Dietetics Education, then the applicant shall demonstrate at least forty-five (45) semester hours or sixty-eight (68) quarter hours, as evidenced by a certified copy of an academic transcript, of coursework at the baccalaureate or graduate level in addition to the hours required by KRS 310.031(2)(b). The coursework shall include content specific to each of the following areas:

(a) Communication;
(b) Counseling;
(c) Physical and biological sciences;
(d) Social sciences;
(e) Research;
(f) Food composition;
(g) Nutrient metabolism;
(h) Food systems management;
(i) Nutrition therapy;
(j) Lifecycle nutrition; and
(k) Healthcare systems.

(3) The twelve (12) semester hours of graduate credit required by KRS 310.031(2)(b) shall include only didactic hours of graduate credit specifically related to human nutrition. Examples include:

(a) Food sources of nutrients;
(b) Physiological and chemical processes of digestion, absorption, and metabolism;
(c) Nutrition needs throughout the life cycle;
(d) Nutrition assessment processes;
(e) Pathophysiology of disease states;
(f) Medical nutrition therapy;
(g) Nutrient needs in exercise and fitness; and
(h) Nutrition in health and wellness.

(4) The twelve (12) semester hours of graduate credit required by KRS 310.031(2)(b) shall not include practicums, courses that are primarily obtained from work experiences, independent study, thesis, or dissertation credit hours.

Section 4. In order to provide supervision to a licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst, a licensed behavior analyst shall be currently certified by the Behavior Analyst Certification Board as a:

(1) Board Certified Behavior Analyst, BCBA; or
(2) Board Certified Behavior Analyst - Doctoral, BCBA-D (Supervisor Qualifications). (1) Only a behavior analyst who has been certified with the Behavior Analyst Certification Board and are in good standing may provide supervision to a licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst.

(2) Behavior analysts functioning as supervisors shall meet all supervisory qualifications of the Behavior Analyst Certification Board.

Section 3. Supervisor Responsibilities. (1) Except as provided in Section 16 of this administrative regulation, a supervisory arrangement shall be submitted to the board using the Application for Licensure Form, with the supervisor and the licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst petitioning the board to submit to the board the description of the supervisory arrangement or a change in the supervisory arrangement by submitting an updated Annual Supervisory Plan no later than thirty (30) days after a change in the effective date of the arrangement or change.

Section 4. The supervisor shall make all reasonable efforts to be assured that the practice of each licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst is in compliance with this administrative regulation. The supervisor shall include review, discussions, and recommendations and shall focus on:

(a) Focusing on Case background information;
(b) Planned behavioral assessment procedures;
(c) Assessment outcomes;
(d) Data collection procedures;
(e) Intervention procedures and materials;
(f) Intervention outcome data;
(g) Modifications of intervention procedures;
(h) Ethical issues associated with behavior change services or
professional development needs and opportunities.

(2) The supervisor shall report to the board an apparent violation of KRS Chapter 319C on the part of the licensed assistant behavior analyst, temporarily licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed behavior analyst

(3) The supervisor shall inform the board immediately of a change in the ability to supervise, or in the ability of a licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst to function in the practice as a licensed and behavior analyst, temporarily licensed behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor as appropriate to insure that these duties are competently performed.

(4) The supervisor shall control, direct or limit the behavior analytic duties performed by the licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor.

(b) If the board initiates an investigation concerning a licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor, the investigation shall include the supervisor of record.

(c) For each person supervised, the supervisor shall maintain a record of each supervisory session that shall include the type, place, and general content of the session.

(b) This record shall be maintained for a period of not fewer than six (6) years after the last date of supervision.

Section 5. (1) In calculating the amount of time spent in full-time practice while under supervision, 1,500 hours of satisfactory supervised practice shall be equivalent to one (1) year of experience.

(2) The board may require additional supervised practice if recommended by the supervisor on a licensee’s Annual Supervisory Plan or Annual Report of Supervision.

(3) The supervisor shall provide reports to the board of the supervision of each licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor as follows:

1. According to the schedule established in the following subsections.

(a) A licensed assistant behavior analyst with five (5) or more years of full-time practice, or its equivalent, shall submit a report every two (2) years on the anniversary of the date of licensure as a licensed assistant behavior analyst.

(b) A licensed assistant behavior analyst with fewer than five (5) years of full-time practice, or its equivalent, shall submit a report annually on the anniversary of the date of licensure as a licensed assistant behavior analyst.

(c) A temporarily licensed behavior analyst or temporarily licensed assistant behavior analyst shall submit a report annually on the anniversary of the date of licensure as a temporarily licensed behavior analyst or temporarily licensed assistant behavior analyst.

(b) The report shall be submitted on the Annual Report of Supervision which shall include:

1. (a) A description of the frequency, format, and duration of supervision;

2. An assessment of the functioning of the licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst, including the strengths and weaknesses of the supervisee; and

3. Any other information which the supervisor deems relevant to an adequate assessment of the practice of the licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst.

Section 6. (1) If a licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst has more than one (1) board-approved supervisor, the supervisors shall be in direct contact with each other at least once every six (6) months and three (3) times during the annual supervised practice plans and reports to the board and copies to each other.

(2) A request to have more than two (2) supervisors at one (1) time shall be subject to board approval and shall be submitted by new applicants on the licensure application and the Annual Supervisory Plan and by existing licensees on the Annual Supervisory Plan, which shall include detailed information as to how the supervisors shall communicate and coordinate with each other in providing the required supervision.

Section 7. If a licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor is a behavior analyst with less than five (5) years of full-time, post-certification practice, or its equivalent, or a licensure candidate with temporary permission to practice, the supervisor of record shall:

(a) Be updated or revised and submitted to the board with the regular report of supervision;

(b) Include intended format, and goals to be accomplished through the supervisory process; and

(c) Include methods that the supervisor and the certified assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor shall employ to evaluate the supervisory process:

(1) Have general supervision of the work performed by the certified assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor at least twice per month;

(2) Have direct supervision of the work performed by the certified assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor at least once every three (3) months;

(3) Have direct knowledge of the size and complexity of the caseload for each certified assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor;

(4) Limit and control the caseload as appropriate to the level of competence of each certified assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst practicing under the direction of the supervisor when it has a direct bearing on his or her competence to practice.

Section 8. If the licensed assistant behavior analyst or temporarily licensed behavior analyst is a behavior analyst with more than five (5) years of full-time, post-certification practice, or its equivalent, the supervisor of record shall:

(a) Review and countersign all assessments;

(b) Review treatment plans, notes, and correspondence as needed or appropriate;
(3) Jointly establish a supervisory plan with each licensed assistant behavior analyst, or temporarily licensed behavior analyst, practicing under the direction of the supervisor, which shall be submitted to the board at the beginning of the supervisory relationship using the Annual Supervisory Plan. The plan shall:
(a) Be updated or revised and submitted to the board with the regular report of supervision;
(b) Include intended format, and goals to be accomplished through the supervisory process; and
(c) Include methods that the supervisor and licensed assistant behavior analyst, or temporarily licensed behavior analyst, practicing under the direction of the supervisor shall employ to evaluate the supervisory process;
(4) Have general supervision of the work performed by each licensed assistant behavior analyst or temporarily licensed behavior analyst practicing under the direction of the supervisor at least once per month;
(5) Have direct supervision of the work performed by each licensed assistant behavior analyst or temporarily licensed behavior analyst practicing under the direction of the supervisor at least twice a year;
(6) Have direct knowledge of the size and complexity of the caseloads for each licensed assistant behavior analyst or temporarily licensed behavior analyst practicing under the direction of the supervisor;
(7) Limit and control the caseload as appropriate to the level of competence of each licensed assistant behavior analyst or temporarily licensed behavior analyst;
(8) Have knowledge of the techniques being used by each licensed assistant behavior analyst or temporarily licensed behavior analyst; and
(9) Have knowledge of the physical and emotional well-being of each licensed assistant behavior analyst or temporarily licensed behavior analyst practicing under the direction of the supervisor when it has a direct bearing on his or her competence to practice.

Section 9. Supervision Requirements. (1)(a) A[All] licensed assistant behavior analyst[analysts] shall meet these supervision requirements, even if he or she is not currently providing behavior analytic services.
(b) If the licensed assistant behavior analyst is not currently providing behavior analytic services, they are not currently providing behavior analytic services. If not currently providing behavior analytic services, supervision may focus on guiding the development and maintenance of the licensed assistant behavior analyst's professional knowledge and skills and remaining current with the professional literature in the field.
(2) Upon resumption of practice, the licensed assistant behavior analyst shall document compliance with continuing education requirements and shall report on his or her activities and employment related to behavior analysis during the period in which the analyst[applicant] did not practice.

Section 10. Supervision for Part-Time Practice. Supervision requirements for part-time practice may be modified at the discretion of the board upon approval of the submitted plan. Additional modifications of the format, frequency, or duration of supervision may be submitted for approval by the board.

Section 11. Supervisory Changes. (1) Upon a change of supervisor, an updated Annual Supervisory Plan shall be submitted by the supervisor and licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst to the board for approval. This plan may require additional supervision than was previously approved by the board.
(2) Upon termination of the supervisory relationship, the final Annual Report of Supervision shall be submitted to the board within thirty (30) days of the termination.

Section 12. Responsibilities of the licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst. The licensed assistant behavior analyst, temporarily licensed behavior analyst, or temporarily licensed assistant behavior analyst shall:
(1) Keep the supervisor adequately informed at all times of his or her activities and ability to function;
(2) Seek supervision as needed in addition to a regularly scheduled supervisory session;
(3) Participate with the supervisor in establishing supervisory goals and in completing the regular supervisory reports;
(4) Be jointly responsible with the supervisor for ensuring that a supervisory report or plan has been sent to the board in accordance with the reporting schedule established in Section 5 of this administrative regulation; and
(5) Report to the board any apparent violation of KRS Chapter 319C on the part of the supervisor.

Section 13. Identification of Provider in Billing. The actual deliverer of a service shall be identified to the client. A billing for a rendered service shall identify which service was performed by the assistant[associate] behavior analyst, temporarily licensed behavior analyst, trainee, or other provider and supervised by the licensed behavior analyst.

Section 14. Disciplinary Procedures and Supervision of a Disciplined License Holder. (1) The board shall appoint an approved supervisor to supervise a disciplined license holder for the period of time defined by the final order or settlement agreement concerning the discipline.
(2) When specified by the final order or settlement agreement, the disciplined license holder shall be responsible for paying the costs of supervision.
(3) The supervisor shall:
(a) Review the originating complaint, agreed order, or findings of the disciplinary hearing;
(b) Meet with the disciplined license holder and the board liaison to:
1. Summarize the actions and concerns of the board;
2. Review the goals and expected outcomes of supervision submitted by the board liaison;
3. Develop a specific plan of supervision; and
4. Review the reporting requirements that shall be met during the period of supervision;
(c) Meet with the disciplined license holder at least weekly, on an individual face-to-face basis for a minimum of one (1) hour unless modified by the board;
(d) Submit a quarterly report to the board which reflects progress, problems, and other information relevant to the need for board-mandated supervision;
(e) Make all reasonable efforts to ensure that the disciplined license holder's practice is in compliance with KRS Chapter 319C and 201 KAR Chapter 43;
(f) Report to the board any apparent violation of KRS Chapter 319C on the part of the disciplined license holder;
(g) Immediately report to the board, in writing, a change in the ability to supervise, or in the ability of the disciplined license holder to function in the practice of a licensed behavior analyst in a competent manner;
(h) Review and countersign assessments as needed or appropriate;
(i) Review treatment plans, notes, and correspondence as needed or appropriate;
(j) Have direct observation of the disciplined license holder's work on an as-needed basis;
(k) Have direct knowledge of the size and complexity of the disciplined license holder's caseload;
(l) Have knowledge of the therapeutic modalities and techniques being used by the disciplined license holder; and
(m) Have knowledge of the disciplined license holder's physical and emotional well-being when it has direct bearing on the disciplined license holder's competence to practice.
(4)(5)[4](5) The supervisor shall control, direct, or limit the disciplined license holder's practice as appropriate to ensure that the disciplined license holder's practice is competent.
(5)[6] The supervisor shall contact the board liaison with any concern or problem with the disciplined license holder, his or her
practice, or the supervision process.

(6)(a)[(2)] A final meeting shall be scheduled within thirty (30) days of the end of the established supervision period to summarize the supervision.

(b) The meeting shall include the supervisor, disciplined license holder, and board liaison.

(c) A written summary of the supervision shall be submitted by the supervisor to the board two (2) weeks following this meeting with a copy to the board liaison.

Section 15. Board Liaison for Disciplined License Holder. The board shall appoint a board member to serve as a liaison between the board and the approved supervisor. The board liaison shall:

(1) Recruit the supervising licensed behavior analyst from a list provided by the board;

(2) Provide the supervising licensed behavior analyst with the originating complaint, agreed order or findings of the hearing and supply other material relating to the disciplinary action as deemed appropriate by the board;

(3) Ensure that the supervising licensed behavior analyst is provided with the necessary documentation for liability purposes to clarify that he or she is acting as an agent of the board and has immunity commensurate with that of a board member;

(4) Provide the supervising licensed behavior analyst with a written description of the responsibilities of the supervisor and a copy of the responsibilities of the liaison;

(5) Ensure that the board has sent a written notification letter to the disciplined license holder. The notification letter shall:

(a) State the name of the supervising licensed behavior analyst;

(b) Specify that the disciplined license holder shall meet with the supervising licensed behavior analyst and the liaison within thirty (30) days of the date of the notification letter;

(6) Meet with the supervising licensed behavior analyst and disciplined license holder within thirty (30) days of the date of the notification letter to summarize the actions of the board, review the applicable statutes and administrative regulations regarding supervision for a disciplined license holder, and assist with the development of a plan of supervision. The plan of supervision shall be written at the first meeting;

(7) Submit the report of supervision to the board for approval.

(a) The board liaison shall place the report of supervision on the agenda for review and approval at the next regularly scheduled board meeting.

(b) In the interim, the supervising licensed behavior analyst and disciplined license holder shall continue to meet;

(c) Remain available to the supervising licensed behavior analyst and disciplined license holder to provide assistance and information as needed;

(9) Report any problem or concern to the board regarding the supervision and communicate a directive of the board to the supervising licensed behavior analyst;

(10) Review the quarterly report of supervision and forward to the supervision committee of the board for approval; and

(11) Meet with the supervising licensed behavior analyst and the disciplined license holder at the end of the term of supervision to summarize the supervision.

Section 16. Graduate Training. Applied behavior analysis graduate students. Graduate-level applied behavior analysis students who are providing services in mental health care settings including independent practice settings shall:

(1) Be supervised by a behavior analyst licensed by the board in the state in which the training program exists, or by a licensed mental health professional approved by the training program who is affiliated with either the university training program or the practice setting;

(2) Be registered for credit in his or her course of study;

(3) Clearly identify his or her status as unlicensed trainees to all clients and payors;

(4) Give to all clients and payors the name of the licensed behavior analyst responsible for his or her work; and

(5) Not accept employment or placement to perform the same or similar activities following the completion of his or her university-sanctioned placement, regardless of the job title given, unless the student holds a license from the board.

Section 17. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Annual Report of Supervision", October 2012; and

(b) "Annual Supervisory Plan", October 2012.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Division of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky 40602, (502) 564-3296, Monday through Friday, 8 a.m. to 4:30 p.m.

SHELLI DESKINS, Chair
APPROVED BY AGENCY: September 24, 2012
FILED WITH LRC: October 11, 2012 at 3 p.m.
CONTACT PERSON: Lindsey Lane, Board Administrator, Kentucky Applied Behavior Analyst Licensing Board, PO Box 1370, Frankfort, Kentucky 40602.

TOURISM, ARTS AND HERITAGE CABINET
Kentucky Department of Fish and Wildlife Resources
(As Amended at ARRS, January 7, 2013)

301 KAR 2:222. Waterfowl hunting requirements on public lands.

RELATES TO: KRS 150.010(40), 150.305(1), 150.330, 150.340(1), (3), 150.990
STATUTORY AUTHORITY: KRS 150.025(1), 150.360, 150.600(1), 50 C.F.R. 20, 21
NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish open seasons for the taking of wildlife and to regulate bag limits. KRS 150.360 authorizes the department to restrict methods of taking wildlife. KRS 150.600(1) authorizes the department to regulate the taking of waterfowl on public and private land. This administrative regulation establishes procedures for the taking of waterfowl within reasonable limits and within the frameworks established by 50 C.F.R. Parts 20 and 21.

Section 1. Definitions. (1) "Blind" means a:

(a) Concealed enclosure;

(b) Pit; or

(c) Boat.

(2) "Department blind" means a permanently fixed blind structure built by the department.

(3) "Hunt site" means a specific location where waterfowl hunting is allowed, as approved by the department or the U.S. Army Corps of Engineers.

(4) "Layout blind" means a portable blind that when fully deployed allows one (1) person to be concealed above the surface of the ground.

(5) "Party" means:

(a) A person hunting alone; or

(b) Two (2) to four (4) people who share a department blind or hunt site.

(6) "Permanent blind" means a blind left in place by a waterfowl hunter longer than twenty-four (24) hours.

(7) "Regular waterfowl season" means the open waterfowl season that does not include the Light Goose Conservation Order or the September wood duck, teal, and Canada goose seasons as established in 301 KAR 2:221 and 2:225.

(8) "Waterfowl" is defined in KRS 150.010(40).

(9) "Wildlife Management Area" or "WMA" means a tract of land:

(a) Controlled by the department through ownership, lease, license, or cooperative agreement; and

(b) That has "Wildlife Management Area" or "WMA" as part of its official name.

Section 2. Shot requirements. A person hunting waterfowl shall not use or possess a shotgun shell:

(1) Longer than three and one-half (3 1/2) inches; or

(2) Containing:
(a) Lead shot;
(b) Shot not approved by the U.S. Fish and Wildlife Service for waterfowl hunting; or
(c) Shot larger than size "T".

Section 3. (1) Except as specified in this section or in Section 4 of this administrative regulation, on a Wildlife Management Area:
(a) A person hunting waterfowl shall not:
   1. Establish or hunt from a permanent waterfowl blind;
   2. Hunt within 200 yards of:
      a. Another occupied hunt site;
      b. Another legal waterfowl hunting party; or
      c. An area closed to waterfowl hunting;
   (b) A person shall not hunt in a designated recreation area or access point;
   (c) More than four (4) persons shall not occupy a waterfowl blind or hunt site; and
   (d) A hunter shall remove decoys and personal items daily, except that a hunter drawn for a mullday hunt may choose to leave decoys in place for the duration of the hunt.
(2) A person wanting to establish or use a permanent waterfowl blind or hunt site on Lake Barkley, Barren River Lake, Buckhorn Lake, Green River Lake, Nolin River Lake, Paintsville Lake, Rough River Lake, Sloughs, or Doug Travis Wildlife Management Areas:
   (a) Shall first obtain a waterfowl blind permit from the U.S. Army Corps of Engineers or the department;
   (b) May designate one (1) other person as a partner; and
   (c) Shall not hold more than one (1) permit per area.
(3) A person who participates in a drawing for a hunt site permit shall:
   (a) Be at least eighteen (18) years of age; and
   (b) Possess:
      1. A valid Kentucky hunting license;
      2. A Kentucky waterfowl permit; and
      3. A federal duck stamp.
(4) The holder of a hunt site permit shall:
   (a) Construct or establish the blind or hunt site before November 20 or forfeit the permit;
   (b) Not lock a waterfowl blind; and
   (c) Remove the blind and blind materials within thirty (30) days after the close of the regular waterfowl season or be ineligible for a permit the following year, unless an extension of time is granted by the department based on weather or water level conflicts.
(5) A permanent blind, department blind, or blind site not occupied by the permit holder one (1) hour before sunrise shall be available to another hunter on a first-come, first-served basis.
(6) A waterfowl blind restriction established in this section shall not apply to a falconer if a gun or archery season is not open.

Section 4. Wildlife Management Area Requirements. (1) The regular waterfowl season provisions shall apply, as established in 301 KAR 2:221, except as established in this section.
(2) The provisions of this section shall not apply to a waterfowl hunting season that opens prior to October 15, as established in 301 KAR 2:221, except as established in this section.
(3) A person shall not:
   (a) Hunt on an area marked by a sign as closed to hunting;
   (b) Enter an area marked by signs as closed to public access; or
   (c) Hunt a species on an area marked by signs as closed to hunting for that species.
(4) On Wildlife Management Areas in Ballard County:
   (a) The shotgun shell possession limit shall be fifteen (15), except that the shotgun shell possession limit shall be twenty-five (25) if:
      1. The daily bag limit for ducks is greater than three (3); and
      2. The daily bag limit for Canada goose is greater than or equal to two (2)
   (b) At least one (1) person in a waterfowl blind shall be eighteen (18) years of age or older if hunting in a department waterfowl blind or hunt site at Ballard or Boatwright WMA.
(5) At Ballard WMA:
   (a) The duck, coot, merganser, and goose season shall be December 5 through January 27;
   (b) [and merganser season shall be December 7 through January 29.]
   (c) [and]
   (d) [A person hunting waterfowl shall not hunt on Monday, Tuesday, Christmas Day, or New Year's Day.]
   (e) [A person hunting waterfowl shall:
      1. Apply for the waterfowl quota hunt as established in Section 5(6) of this administrative regulation;
      2. Not hunt waterfowl on the Ohio River from fifty (50) yards upstream of Dam 53 to fifty (50) yards downstream from the southern border of Ballard Wildlife Management Area from October 15 through March 15; and
      3. Exit the area by 2 p.m. during the regular waterfowl season, except as authorized by the department.
   (f) [At Boatwright WMA, including the Olmsted, Peal, and Swan Lake units:
      (a) A party shall:
         1. Not hunt on Monday, Tuesday, Christmas Day, or New Year's Day;
         2. Obtain a daily check-in card by 8 a.m. before entering the area from December 5 through January 27, and January 29.
      (b) [Check out the same day by:
         a. Visiting the designated Check station prior to 8 a.m.; or
         b. Depositing the check-in card at a department-designated drop point after 8 a.m.;
      (c) Duck season shall be open one-half (1/2) hour before sunrise to sunset beginning Thanksgiving Day for four (4) consecutive days on areas of Boatwright WMA that are open to hunting.
      (d) A department blind or hunt site shall be offered to another hunter on a first-come, first-served basis, if the blind or hunt site has not been assigned during the daily drawing.
      (e) Waterfowl hunters shall exit the area by 2 p.m. during the regular waterfowl season;
      (f) A boat blind shall not be permitted in flooded timber, except:
         1. During periods of flood if no other access is possible; or
         2. A mobility-impaired hunter may hunt from a boat.
      (g) A party shall only hunt waterfowl:
         1. From a department blind; or
         2. From layout blinds set so that all layout blinds in the party lie within a twenty-five (25) foot radius from the center of the party, and within 200 yards of a blind site in December and January during the regular waterfowl season.
      (h) On the Peal unit:
         1. More than seven (7) parties shall not hunt at the same time on Buck Lake or Flat Lake;
         2. More than four (4) parties shall not hunt at the same time on Fish Lake;
         3. More than three (3) parties shall not hunt at the same time on First Lake or Second Lake;
         4. A party shall not hunt waterfowl except within twenty-five (25) feet of a hunt site during December and January.
      (i) On the Swan Lake Unit:
         1. A person shall not hunt waterfowl from November 22 through December 5 or December 26 through December 30.
      (j) [The area open to hunting during the regular waterfowl season shall be open for the Light Goose Conservation Order season as established in 301 KAR 2:221; and
      (k) [Blind restrictions shall not apply to the Light Goose Conservation Order season.
   (7) Lake Barkley WMA:
      (a) A permanent blind shall only be established within ten (10) yards of a blind site;
      (b) Waterfowl refuge areas:
         1. The area west of the Cumberland River channel, as marked by buoys, between river mile fifty-one (51), at Hayes Landing Light, south to the Tennessee Valley Authority's power transmission lines at river mile fifty-five and five-tenths (55.5) shall be closed from
November 1 through February 15; and
2. The area within Honker Bay and Fulton Bay, as marked by
buoys and signs, shall be closed from November 1 through March
15.
(c) A person shall not hunt from October 15 through March 15:
1. On Duck Island; or
2. Within 200 yards of Duck Island.
(8) Barren River Lake WMA. A person hunting waterfowl:
(a) May use a breech-loading shotgun along the shoreline of
the Peninsula Unit; and
(b) Shall not use a breech-loading firearm elsewhere on the
area.
(9) Miller Welch-Central Kentucky WMA. A person shall not
hunt waterfowl from October 15 through January 14.
(10) Lake Cumberland WMA. The following sections shall be
closed to the public from October 15 through March 15:
(a) The Wesley Bend area, bounded by Fishing Creek, Beech
Grove Road and Fishing Creek Road; and
(b) The Yellowhole area, bounded by Fishing Creek Road and
Hickory Nut Road.
(11) Pioneer Weapons WMA. A person hunting waterfowl:
(a) May use a breech-loading shotgun along the shoreline of
Cave Run Lake; and
(b) Shall not use a breech-loading firearm elsewhere on the
area.
(12) Doug Travis WMA.
(a) Shooting hours shall be one-half (1/2) hour before sunrise
until 2 p.m.
(b) A person shall not enter a hunting area prior to 4 a.m. daily.
(c) A person hunting waterfowl shall exit the area by 2 p.m.
during waterfowl season, except as authorized by the department.
(d) On Black Lake, Fish Lake, Forked Lake, Indian Camp Lake,
Number Four Lake, and Upper Goose Lake, all waterfowl hunting
after November 1:
1. Shall be from hunt sites assigned by a random preseason
drawing; and
2. Shall be within ten (10) yards of a hunt site, including pe-
riods of Mississippi River flooding.
(13) Grayson Lake WMA. A person shall not hunt waterfowl:
(a) Within the no-wake zone at the dam site marina;
(b) From the shore of Camp Webb;
(c) On Deer Creek Fork; and
(d) Within three-quarters (3/4) of a mile from the dam.
(14) Green River Lake WMA.
(a) Shooting hours shall be one-half (1/2) hour before sunrise
until 2 p.m.
(b) A person shall not enter a hunting area prior to 4 a.m. daily.
(15) Kaler Bottoms WMA.
(a) Shooting hours shall be one-half (1/2) hour before sunrise
until 2 p.m.
(b) A person shall not enter a hunting area prior to 4 a.m. daily.
(16) Land Between the Lakes National Recreation Area.
(a) The following portions shall be closed to the public from
November 1 through March 15:
1. Long Creek Pond;
2. The eastern one-third (1/3) of Smith Bay, as marked by
buoys; and
3. The eastern two-thirds (2/3) of Duncan Bay, as marked by
buoys:
(b) The following portions shall be closed to waterfowl hunting:
1. The Environmental Education Center; and
2. Energy Lake.
(c) A person shall possess an annual Land Between the Lakes
Hunting Permit if hunting waterfowl:
1. Inland from the water's edge of Kentucky Lake or Barkley
Lake; or
2. From a boat on a flooded portion of Land Between the
Lakes when the lake level is above elevation 359.
(d) A person shall not hunt waterfowl on inland areas during a
quota deer hunt:
(e) A person shall not establish or use a permanent blind:
1. On an inland area; or
2. Along the Kentucky Lake shoreline of Land Between the
Lakes.
(f) A person hunting waterfowl shall remove decoys and per-
sonal items daily.
(17) Obion Creek WMA.
(a) Shooting hours shall be one-half (1/2) hour before sunrise
until 2 p.m.
(b) A person shall not enter a hunting area prior to 4 a.m. daily.
(18) Ohio River Islands WMA.
(a) A person shall not hunt from October 15 through March 15
on the Kentucky portion of the Ohio River from Smithland Lock and
Dam upstream to the power line crossing at approximately river
mile 911.5.
(b) Stewert Island shall be closed to public access from Octo-
ber 15 through March 15.
(c) Shooting hours shall be one-half (1/2) hours before sunrise
until 2 p.m.
(d) A person shall not enter a hunting area prior to 4 a.m. daily.
(19) Peabody WMA.
(a) Shooting hours shall be one-half (1/2) hour before sunrise
until 2 p.m.
(b) A person shall not enter a hunting area prior to 4 a.m. daily.
(c) The following areas, as posted by signs, shall be closed to
the public from October 15 through March 15:
1. The Sinclair Mine area, bounded by Hwy 176, the haul road,
and Goose Lake Road; and
2. The Ken area, bounded by Wysox Road, H2 Road, H1
Road, and H6 Road.
(20) Robinson Forest WMA. The main block of the WMA shall
be closed to waterfowl hunting.
(21) Sloughs WMA.
(a) Shooting hours shall be one-half (1/2) hour before sunrise
until 2 p.m.
(b) A person shall not enter a hunting area prior to 4 a.m. daily.
(c) A person hunting waterfowl shall exit the area by 2 p.m.
during the regular waterfowl season.
(d) On the Grass-Creek Powell's Lake Unit, a person hunting
waterfowl:
1. Shall hunt:
a. From a department blind; or
b. From a blind within twenty-five (25) yards of a blind site.
2. Shall remove decoys and personal items from the area on a
daily basis.
(e) On the Jenny Hole-Highlands Creek Unit, a person hunting
waterfowl:
1. Shall hunt:
a. From a department blind; or
b. Within twenty-five (25) yards of a hunt site; or
2. Shall remove decoys and personal items from the area on a
daily basis.
(f) If the Ohio River reaches a level that requires boat access,
a waterfowl hunter:
1. May hunt from a boat without regard to department blinds; and
2. Shall not hunt closer than 200 yards from another boat.
(g) A person hunting waterfowl on the Crenshaw and Duncan
Tracts of the Sauerheber Unit:
1. Shall hunt from a blind assigned by the department through a
drawing as established in Section 5[4][a] of this administrative regu-
lation;
2. May occupy a permitted blind if not claimed by the permittee
within one (1) hour before sunrise;
3. Shall not possess more than fifteen (15) shotgun shells,
except that the shotgun shell possession limit shall be twenty-five
(25) if:
3.1[4][a] The daily bag limit for ducks is greater than three (3); and
3.2[4][a] The daily bag limit for Canada goose is greater than or
equal to two (2);
4. Shall be accompanied by an adult if under eighteen (18)
years of age; and
5. The waterfowl blind for a mobility-impaired person shall be
open to the public if the permit holder or another mobility-impaired
person has not claimed the blind on that day by one (1) hour be-
fore sunrise.
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(h) The Crenshaw and Duncan II tracts of the Sauerheber Unit shall be closed to hunting except for:
1. Waterfowl from November 1 through March 15; and
2. The modern gun deer season.
(i) The remainder of the Sauerheber Unit shall be closed to the public from November 1 through March 15.
(j) A hunter drawn to hunt Sloughs WMA through a preseason draw shall submit a completed department-issued survey at the conclusion of the hunt or shall be ineligible to participate in the waterfowl blind or quota draw the following year.

(22) South Shore WMA.
(a) The WMA shall be closed to hunting from November 15 through January 15, except for waterfowl quota hunting and dove hunting.
(b) A hunter shall use a department blind.
(c) A department blind shall be available daily on a first-come, first-served basis.

(23) Taylorsville Lake WMA.
(a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.
(b) A person shall not enter a hunting area prior to 4 a.m. daily.

(24) Yatesville Lake WMA. The following areas shall be closed to waterfowl hunting, unless authorized by Yatesville Lake State Park:
(a) The Greenbrier Creek embayment; and
(b) The lake area north from the mouth of the Greenbrier Creek embayment to the dam, including the island.

(25) Yellowbank WMA. The area designated by a sign and painted boundary marker shall be closed to the public from October 15 through March 15.

Section 5. (1) A person applying to hunt waterfowl on Ballard WMA or the Sauerheber Unit of Sloughs WMA shall:
(a) Apply through the vendor supplied by the department by calling 1-877-598-2401, or by completing the online application process on the department’s Website at fw.ky.gov; and
(b) Apply from September 1 through September 30;
(c) Pay a three ($3) dollar application fee for each application; and
(d) Not apply more than one (1) time for each hunt.
(2) A person drawn to hunt may bring up to three (3) additional hunters.
(3) A person shall be declared ineligible to hunt in department waterfowl quota hunts during the remaining portion of the waterfowl season and declared ineligible to apply for any department quota hunt for the following year if the hunter violates state or federal regulations while waterfowl hunting on WMAs that have a preseason or daily drawing.

Section 6. State Parks. (1) Waterfowl hunting shall be prohibited, except there shall be an open waterfowl hunt December 13 through January 31 on designated areas of Barren River, Grayson Lake, Greenbo Lake, Lake Barkley, Lincoln Homestead, Nolin Lake, Paintsville Lake, Pennyrile Lake, Rough River Lake, and Yatesville Lake State Parks.
(2) Hunters shall check in each day at the front desk of the state park or a designated check-in location on days that the park office is not open.
(3) During check-in hunters shall be provided a map showing designated areas of the park that are open to waterfowl hunting.
(4) Hunters shall check out each day at the front desk of the state park or a designated check-out location on days that the park office is not open.
(5) Statewide waterfowl hunting requirements shall apply.

Section 7. Youth-Mentor and Mobility-Impaired Waterfowl Hunts. (1) There shall be youth-mentor waterfowl hunts on the Minor Clark and Peter W. Pfeiffer fish hatcheries each Saturday and Sunday in January.
(2) There shall be a mobility-impaired waterfowl hunt at Minor Clark Fish Hatchery that is held concurrently with each youth-mentor hunt.

(3) A youth or mobility-impaired person shall register in advance and carry a department provided postcard notification on the day of the hunt.
(4) A mobility-impaired person shall also submit a mobility-impaired access permit.
(5) Each youth shall be accompanied by an adult who is eighteen (18) years or older.
(6) Each youth shall not be accompanied by more than one (1) adult.
(7) One (1) adult may accompany two (2) youths.
(8) A mobility-impaired hunter may be accompanied by no more than one (1) assistant who may also hunt.
(9) A person shall hunt from an established blind and shall not change blinds.
(10) A blind shall not be used by more than four (4) hunters.
(11) A person shall only discharge a firearm from a blind.
(12) A person shall not possess more than fifteen (15) shotshells.
(13) A waterfowl hunter, mentor, or assistant shall immediately retrieve downed birds.
(14) A person shall encase a firearm if traveling to and from a blind.
(15) Hunting shall end at noon, and hunters shall exit the area by 1 p.m.
(16) All decoys and equipment shall be removed at the end of each day’s hunt.
(17) A hunter shall report harvest by depositing a completed hunt permit at the designated location.

BENJY KINMAN, Deputy Commissioner
For DR. JONATHAN GASSETT, Commissioner
MARCHETA SPARROW, Secretary
FILED WITH LRC: October 31, 2012 at noon

ENERGY AND ENVIRONMENT CABINET
Department for Natural Resources
Division of Mine Reclamation and Enforcement
(As Amended at ARRS, January 7, 2013)

405 KAR 5:032. Permit requirements.

RELATES TO: KRS 350.010(2), 350.130, 350.240, 350.300
STATUTORY AUTHORITY: KRS 350.028, 350.029, 350.240, 350.300

NECESSITY, FUNCTION, AND CONFORMITY: KRS 350.028 authorizes the Energy and Environment Cabinet to promulgate administrative regulations pertaining to noncoal mineral operations to minimize their adverse effects on the citizens and the environment of the commonwealth. KRS 350.029 authorizes the cabinet to promulgate reasonable administrative regulations to establish effective programs for the control of surface soil disturbance in connection with mining as defined by the Interstate Mining Compact. KRS 350.240 authorizes the cabinet to promulgate reasonable administrative regulations for the reclamation of land disturbed or removed in the mining of clay. KRS 350.300 authorizes the cabinet to formulate and establish an effective program and standards for the conservation and use of mined land. This administrative regulation specifies certain information to be submitted by the applicant relating to legal status, financial information, general site information, map requirements, cultural and environmental resource information, and mining and reclamation plans. This administrative regulation also addresses the waivers and approvals necessary to conduct noncoal mineral operations, including those of other agencies, and establishes provisions concerning review of permits and other permit related procedures.

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Section 1. General. (1) This administrative regulation shall pertain to any person who applies for a permit to conduct mineral operations.

(2) Preliminary permit requirements. A person or mineral operator desiring a permit shall submit a preliminary map at a scale one (1) inch equals 400 feet or 500 feet, marked to show the proposed permit area and adjacent areas, including location of access roads, spoil or waste areas, and sedimentation ponds.

(b) Personnel of the cabinet shall conduct, within fifteen (15) working days after filing, an on-site investigation of the area with appropriate persons including representatives of the applicant.

(3) Permanent permit requirements. An original and two (2) complete, separately bound and distinct copies of the application shall be submitted to the cabinet, at the Department for Natural Resources, Division of Mine Reclamation and Enforcement [Field Services], Noncoal Review Branch, #2 Hudson Hollow, Frankfort, Kentucky 40601, or Division of Field Services at one (1) of the following regional offices:

(a) London Regional Office, Regional State Office Building, 85 State Police Road, London, Kentucky 40741-9011;

(b) Madisonville Regional Office, 625 Hospital Drive, Madisonville, Kentucky 41011-1683;

(c) Middleboro Regional Office, 1804 East Cumberland Avenue, Middleburg, Kentucky 40655-1229;

(d) Pikeville Regional Office, 121 Mays Branch Road, Pikeville, Kentucky 41501-9331;

(e) Prestonsburg Regional Office, 3140 South Lake Drive, Suite 6, Prestonsburg, Kentucky 41653-1410.

Section 2. Identification of Interests. (1) Each permit application shall contain the names and addresses of:

(a) The applicant, including[the] phone number;

(b) The registered agent for service of process, if applicable, including[the] phone number;

(c) Owners, partners, or if a corporation, officers or stockholders owning ten (10) percent or more stock;

(d) The project engineer, along[with] registration number and name of associated firm;

(e) A company and engineer[or] which correspondence concerning the subject permit shall be addressed[the];

(f) Surface owners of record within the area proposed for mining, including areas overlying underground workings;

(g) Mineral owners of record within the area proposed for mining, including areas overlying underground workings; and

(h) Surface owners of record within 500 feet of the proposed permit boundary and areas overlying proposed underground workings;

(2) If the company has undergone a name change or changes during the previous five (5) years, the applicant shall list the names.

(3) The legal structure of the applicant shall be specified[the applicant shall specify the applicant’s legal structure].

(4) If the business is owned by an individual or is a partnership, and is performed under an assumed name, the applicant shall specify the county and state where the name is registered.

(5) The applicant shall list previous Kentucky permits held by the applicant or any individual, partnership, or corporation associated with the applicant.

(6) The applicant shall provide the name of the contact person at the site, including[the] phone number.

(7) The applicant shall specify the type of application, along with the permit number.

Section 3. Bond Information. (1) If bond is required pursuant to[under] 405 KAR 5:082, the following information shall be provided in the permit application:

(a) The bond amount per acre;

(b) The total amount of bond; and

(c) The bond type.

(2) If a surety is used, the applicant shall provide the bond number and surety.

(3) If a certificate of deposit is used, the applicant shall provide the bank name and CD number.

(4) If a letter of credit is used, the applicant shall provide the bank name and letter of credit number.

Section 4. Equipment Inventory. The permit application shall contain a list of all equipment, model numbers, and condition of the equipment proposed to be used for removing overburden and reclaiming the affected area of the proposed mineral operation.

Section 5. Waivers and Approvals. (1) If blasting will occur within 300 feet of an occupied dwelling or if mineral extraction will occur within 100 feet of an occupied dwelling, the permit application shall contain a waiver from the owner, acknowledging approval of the activity.

(2) Except where mine access roads or haul roads join the right-of-way, if the proposed mineral operation will occur within 100 feet of the right-of-way of a public road, or if relocation of a public road is proposed, the permit application shall contain proof of notification to and approval from the appropriate agency or government with jurisdiction over the road.

(3) If a permanent pond other than a final pit impoundment with no embankment is proposed, approval from the landowner for the structure and a written acknowledgment from the landowner that the mineral permittee shall have[will have] no continuing maintenance responsibility after permit release shall be required.

(4) If relocation, channelization, or other significant disturbance to a intermittent or perennial stream is proposed, or if the proposed mineral operation will occur within, or in any way impact, a floodplain, wetland, or other water of the commonwealth, the applicant shall obtain the appropriate permits and approvals from the United States Army Corps of Engineers and the Kentucky Division of Water. Approval shall also be required by the cabinet for any disturbances within 100 feet of an intermittent or perennial stream.

(5) If a sedimentation pond other than a storm water discharge is proposed, a KDDES permit from the Kentucky Division of Water shall be required.

(6) If water withdrawal is proposed, a Water Withdrawal Permit shall be obtained from the Kentucky Division of Water.

(7) If there are local zoning regulations, the applicant shall state this in the application to the Division of Mine Reclamation and Enforcement.

If applicable, approval from the owner of the utilities and facilities as provided in 405 KAR 5:015, Section 4(6) shall be required.

Section 6. Right to Mine. The permit application shall contain a signed statement by the applicant attesting that the applicant has the legal right to mine, along with the appropriate date.

Section 7. Verification of Application. The permit application shall contain a statement, signed by the applicant, acknowledging that all statements and representations, made in the application, are true and correct.

Section 8. Map Requirements. The permit application shall include original and two (2) copies of a section of the appropriate United States Geological Survey Topographical Map or an equivalent format which shall:

(1) Delineate the proposed permit area and any area overlying proposed underground workings;

(2) Be of a scale of not more than one (1) inch to 400 feet;

(3) Show the name and location of all streams, rivers, lakes, or other public water bodies; proposed mineral operation;

(4) Show the site slope;

(5) Delineate all proposed access roads onto the proposed mineral operation; and

(6) Show the site location.
stream buffer zones; roads, cemeteries, houses, churches, schools and other public buildings; oil and gas wells; public properties such as, parks, Wildlife Management Areas, and nature preserves, and utility lines on the area to be affected, and within 1,000 feet of the proposed permit boundary;

(8) Locate[any] sites listed on the National Register of Historic Places and[any] known archaeological sites;

(9) Delineate[any] wetlands that may be affected by the proposed mineral operation;

(10) Show the drainage pattern on and away from the area to be affected, including the direction of flow, proposed constructed drainways, natural drainways to be used for drainage, and the streams or tributaries to receive discharges from the proposed mineral operation;

(11) Show[any] proposed pit area, sediment structures, storage areas, and[any] other facilities and features related to the mineral operation;

(12) Provide a north point arrow;

(13) Contain a legend, which shall:
   (a) Provide the company name;
   (b) Provide the application number;
   (c) Provide the county and quadrant names;
   (d) Provide the site coordinates;
   (e) Provide the site address;
   (f) Provide the map scale and contour interval;
   (g) Provide a description of the site location including:
      1. The nearest stream; and
      2. The distance and direction from the nearest road intersection or town;
   (h) Identify each insignia, symbol, number, or letter used to designate features, facilities, or areas;
   (i) Provide acreage breakdowns of the various mineral operation features and facilities including, pit areas, storage areas, sediment structures, access roads, and the total number of acres of area to be affected; and
   (j) Specify the deposit to be mined; and

(14) Provide a signed, notarized statement that the map has been prepared and certified by a professional engineer, registered pursuant to[under] the provisions of KRS Chapter 322. This statement shall read, "I, the undersigned, hereby certify that this map is correct, and shows to the best of my knowledge and belief all the information required by the mineral operation laws and administrative regulations of the state". This statement shall include:
   (a) The engineer’s registration number; and
   (b) The date on which the map was prepared.

Section 9. General Site Information. The permit application shall contain the following general site information:

(1) Location of the mineral operation to include:
   (a) Latitude and longitude;
   (b) The nearest community;
   (c) The name of the nearest stream;
   (d) The nearest public road intersection; and
   (e) The name of the United States Geological Survey quadrangle or quadrangles, in which the proposed mineral operation will occur[.]

(2) A county by county list of the types of disturbances planned, accompanied by the acreage to be involved with each disturbance[.]

(3) Specification of the mineral to be extracted[.]

(4) Specification of the major watershed or watersheds, which will be affected by the proposed mineral operation[.]

(5) Specification[if[whether any]] active discharges exist that may affect the proposed mineral operation. If so, provide the following information:
   (a) The pH of the discharge; and
   (b) The source of the discharge[.]

(6) Specification[if[whether any]] underground workings will be encountered, and the distance, in feet, to the nearest active deep mine[.]

(7) Specification of the types of disturbances planned for the proposed mineral operation.

Section 10. Cultural Resource Information. The applicant shall specify[if[whether any]] sites listed on the National Register of Historic Places or[any] known archaeological sites exist within, or adjacent to, the proposed permit boundary.

Section 11. Environmental Resources Information. (1) The applicant shall indicate[if[whether any]] there are[any] Wildlife Management Areas, wildlife refuges, nature preserves, state or national parks, state or national forests, or similar public lands within the vicinity of the proposed mineral operation. If these lands exist, the applicant shall delineate them on the map.

(2) The applicant shall indicate[if[whether any]] disturbances within the channel of, or within 100 feet of, an intermittent or perennial stream are proposed.

(3) The applicant shall indicate[if[whether any]] outstanding resource waters, pursuant to 401 KAR 10:031[401 KAR 5.026 and 401 KAR 5.031], within the vicinity of the proposed mineral operation. If so, the applicant shall delineate these waters on the map.

Section 12. Surface Water Quantity and Quality Protection Plan. The permit application shall contain a surface water quantity and quality protection plan, which shall demonstrate to the satisfaction of the cabinet compliance with 405 KAR 5:050 and 405 KAR 5:055, and shall include the following information:

(1) The number of sedimentation ponds proposed, accompanied by designs, drawings, and specifications for each structure to include:
   (a) The structure number;
   (b) The number of acres to be disturbed within the drainage area;
   (c) The number of acres in the drainage area;
   (d) Sediment storage capacity;
   (e) Storage capacity at the principal spillway;
   (f) Storage capacity at the emergency spillway;
   (g) Spillway capacities;
   (h) Structure height measured from the downstream toe; and
   (i) All other engineering designs, dimensions, and calculations required to demonstrate compliance with 405 KAR 5:050 and 5:055.

(2) If sediment removal becomes necessary, the permit application shall contain a description of how sediment shall will be removed and disposed.

(3) The applicant shall state[if[whether any]] any permanent sedimentation ponds are proposed.

(4) The permit application shall contain descriptions, designs, diagrams, figures, and calculations as necessary to adequately explain and illustrate all other sediment control structures.

(5) The permit application shall contain descriptions, designs, diagrams, figures, and calculations as necessary to adequately explain and illustrate[any] other methods proposed for protecting surface waters.

Section 13. Permanent and Temporary Impoundments. If an impoundment is part of the plan of reclamation or method of mineral operation, the permit application shall contain detailed designs and specifications for the impoundment[that[which]] demonstrates compliance with 405 KAR 5:055.

Section 14. Spoil Handling Plan. The permit application shall contain or be accompanied by a plan for the handling and disposal of spoil, in excess of that involved with backfilling and grading, which shall demonstrate to the satisfaction of the cabinet, compliance with the requirements of 405 KAR 5:062.

Section 15. Toxic Materials Handling Plan. The permit application shall contain, or be accompanied by, a plan for the handling of acid-forming or toxic-forming materials, waste materials, or other unstable materials[that[which]] shall demonstrate, to the satisfaction of the cabinet, compliance with the requirements of 405 KAR 5:062.

Section 16. Backfilling and Grading Plan. The permit application shall contain, or be accompanied by, a plan for backfilling and grading, which shall demonstrate to the satisfaction of the cabinet,
compliance with the requirements of 405 KAR 5:062.

Section 17. Topsoil Handling and Restoration Plan. The permit application shall contain, or be accompanied by, a plan for the handling and restoration of topsoil, which shall demonstrate to the satisfaction of the cabinet, compliance with the requirements of 405 KAR 5:062.

Section 18. Land Use Plan. (1) The permit application shall contain a land use plan, which demonstrates compliance with 405 KAR 5:065, and is consistent with 405 KAR 5:070, that:
(a) Specifies the premining use or uses within, and adjacent to, the proposed permit boundary;
(b) Specifies the intended postmining land use for the proposed permit area; and
(c) If the postmining land use is different from the premining land use, shall provide a discussion justifying the change.
(2) The land uses are listed at 405 KAR 5:085, and are defined in 405 KAR 5:082.

Section 19. Revegetation Plan. The permit application shall contain a revegetation plan which shall demonstrate, to the satisfaction of the cabinet, compliance with the requirements of 405 KAR 5:070, and is consistent with 405 KAR 5:065, and that provides the following information:
(1) Identification of the material that will be redistributed on the regrowth area as a plant growth medium;
(2) Permanent grass species, permanent legume species, and quick cover species to be seeded during revegetation, along with their application rates (pounds/acre);
(3) Tree and shrub species to be planted during revegetation, along with their stocking rates (number/acre); and
(4) The type of mulch to be used, along with the mulching rate (pounds or tons/acre), or other soil stabilization practices to be incorporated.

Section 20. Designs and Attachments. (1) The permit application shall be accompanied by appropriate descriptions, designs, diagrams, figures, and calculations as necessary to adequately explain and illustrate proposed sediment control structures, as required under Sections 12 and 13 of this administrative regulation; spoil disposal fills; access and haul roads; stream crossings; and ditches.
(2) Access and haul road designs shall conform to the specifications established in 405 KAR 5:040.
(3) The designs and plans shall demonstrate, to the satisfaction of the cabinet, compliance with all pertinent requirements of 405 KAR Chapter 5, and shall be certified by a Kentucky-registered professional engineer.

Section 21. Newspaper Advertisement: Publication of Notice of Intention to Mine. (1) An applicant for a new permit required pursuant to KRS Chapter 350, shall publish at least once, a public notice of the application for that permit.
(a) The publication shall be made by advertisement in the newspaper of the largest bona fide circulation in the county where the proposed mining site is located.
(b) If the proposed mining site is in more than one (1) county, publication shall be required in the newspaper of the largest bona fide circulation in each county.
(2) The publication shall be made not less than ten (10) nor more than thirty (30) days prior to the filing of the permit application with the department.
(3) The public notice of the intention to file an application shall be entitled, “Notice of Intention to Mine Noncoal Minerals”, and may be in a manner and form prescribed by the department and shall include at a minimum, though not be limited to, the following:
(a) Name and address of the applicant;
(b) Permit application number;
(c) The location of the proposed mining site; and
(d) A brief description of the kind of mining activity proposed, together with a statement of the amount of acreage affected by the proposed mineral operations.
(4) The applicant for a new permit required by KRS Chapter 350 shall establish the date and place at which the “Notice of Intention to Mine Noncoal Minerals” was published, by attaching to the application proof satisfactory to the cabinet of the time, place, and content of the published notice.

Section 22. Permit Revisions. A revision to a permit shall be obtained if the mineral permittee desires to modify the [sic] mineral operations or make changes to the original permit that does not involve increased acreage. The following stipulations shall apply to permit revisions:
(1) The application for revision shall be filed with the cabinet and approved prior to the date on which the mineral permittee expects to revise the mineral operation;
(2) The term of a permit shall remain unchanged by a revision; and
(3) The application for revision shall be submitted using the “Application for Surface Disturbance Mining Permit Noncoal Mining”, Form NCR-2.

Section 23. Permit Amendments. Upon application by the mineral permittee, the cabinet may amend a valid existing permit, so as to increase the permitted area to be affected by mineral operations under the permit. Applications for amendment may be filed at any time during the term of the permit.
(1) The mineral permittee shall file an application in the same form and with the same content as required for an original permit pursuant to this administrative regulation.
(2) The mineral permittee may need to file a supplemental bond with the cabinet in an amount to be determined, as provided under 405 KAR 5:082, for each additional acre or fraction of an acre.

Section 24. Permit Renewals. A [sic] valid permit issued pursuant to 405 KAR Chapter 5 shall carry with it, the right of succession on the permitted area without the prior written approval of the cabinet.
(1) The mineral permittee shall file an application for renewal in the same form and with the same content as required for the original permit pursuant to this administrative regulation.
(2) The mineral permittee may need to file a supplemental bond with the cabinet in an amount to be determined, as provided under 405 KAR 5:082, for each additional acre or fraction of an acre.

Section 25. Permit Succession. (1) There shall be no succession on the permitted area without the prior written approval of the cabinet.
(2) The initial mineral permittee shall notify the cabinet, in writing, of the proposed succession.
(3) The cabinet may release the first mineral operator from the reclamation responsibility pursuant to 405 KAR Chapter 5 as to that particular mineral operation, except that:
(a) There shall not be release until the successive mineral operator has been issued a permit and has otherwise complied
with the requirements of 405 KAR Chapter 5; and
(b) The successor shall immediately assume, as a part of his obligation pursuant to Section 26 of this administrative regulation, all liability for the reclamation of the area affected by the former permitted mineral operation.
(4) If the cabinet has given its prior written approval to the succession, a successor in interest to a mineral permittee who applies for a successor permit within thirty (30) days of succeeding to the interest, and who obtains immediate bond coverage at least equivalent to the amount of the bond of the original permittee, may continue mineral operations according to the approved permit plan of the original mineral permittee until the successor's application is granted or denied.
(5) The bond coverage provided by the successor in interest shall take effect immediately upon the commencement of mineral operations by the successor.

Section 26. Review of Permits. (1) Within thirty (30) working days of receipt of permit application, the cabinet shall make one (1) of three (3) decisions:
(a) To technically withdraw the permit application;
(b) To deny the permit application; or
(c) To approve the permit application.
(2) If the permit application is technically withdrawn or denied, the thirty (30) working day period shall be stopped on the date of this decision.
(3) The time period shall restart on the date when the permit application is returned with deficiencies corrected.
(4) If the application is not approved, the cabinet shall state the reasons, in writing, for which the application is not approved; and the cabinet may propose modifications, delete areas, or reject the entire application.
(5) If the mineral permittee disagrees with the decision of the cabinet, he or she may, by written notice, request a hearing by the cabinet, pursuant to 405 KAR 5:095.
(6) The cabinet shall notify the applicant by registered mail within twenty (20) days after a decision is made.

Section 27. Criteria for Permit Approval and Denial. An application for a permit and/or mineral operation shall not be approved unless the application affirmatively demonstrates and the cabinet determines on the basis of information stated, established, or set forth in the application, and other available pertinent information, that:
(1) The permit application is accurate, complete, and that the applicant has complied with all requirements of 405 KAR Chapter 5;
(2) The mineral operation proposed can be carried out under the method of mineral operation outlined in the permit application in a manner that will satisfy all requirements of 405 KAR Chapter 5;
(3) The proposed mineral operation shall not constitute a hazard to, or do physical damage to life, to an occupied dwelling, public building, school, church, cemetery, commercial or institutional building, public road, stream, lake, other public property, or to members of the public or their real and personal property.
(a) All necessary measures shall be included in the method of mineral operation in order to eliminate the hazard or damage.
(b) If it is not technologically feasible to eliminate the hazard or damage by adopting specifications in the method of the mineral operation, then that part of the mineral operation shall constitute the cause of the hazard or damage shall be deleted from the application and mineral operation.
(4) The proposed mineral operation shall not adversely affect natural hazard lands or a wild river established pursuant to KRS Chapter 146;
(5) The proposed mineral operation shall not be inconsistent with other mineral operations anticipated in areas adjacent to the proposed permit area.

The proposed permit area is:
(a) Not included within the boundaries of the National Park System, the National Wildlife Refuge System, including study rivers designated under Section 5(a) of the Wild and Scenic Rivers Act (16 U.S.C. 1276(a)), and the National Recreation Areas designated by Act of Congress;
(b) Not included within 300 feet, measured horizontally, of any park, public building, school, church, community, or institutional building;
(c) Not included within 100 feet, measured horizontally, of a cemetery, and access to be provided to a cemetery at all times;
(d) Not within 100 feet, measured horizontally, of the outside right-of-way line of any public road, except:
1. Where mine access roads or haul roads join the right-of-way;
2. Where the cabinet allows the roads to be relocated or allows disturbances within 100 feet of the roads, once the applicant has obtained necessary approval from the governmental authority with jurisdiction over the public road, as required under Section 5 of this administrative regulation; and if after public notice and opportunity for public hearing a written finding is made, by the cabinet, that the interest of the public and the landowners affected thereby shall be protected;
(e) Within the distances specified in Section 5 of this administrative regulation, measured horizontally, of an occupied dwelling unless the applicant submits with the permit application a written affidavit from the owner of the dwelling specifying an allowance, as required by Section 5 of this administrative regulation.
1. This waiver shall be knowingly and intelligently executed, and be separate from a lease or deed, unless the lease or deed contains an explicit waiver.
2. A waiver obtained from previous owners shall remain effective for subsequent owners who had actual or constructive knowledge of the existing waiver when the dwelling was purchased.
(b) A subsequent owner shall be deemed to have constructive knowledge if the waiver has been properly filed in public property records pursuant to KRS 382.110 or if the mining has proceeded to within the distance limit prior to the date of purchase; and
(f) Not within 100 feet of an intermittent or perennial stream unless appropriate permits and approvals, required pursuant to Section 5 of this administrative regulation, have been obtained authorizing mineral operations at a closer distance to, or through, the stream. The authorization shall not be given unless the applicant demonstrates to the satisfaction of the cabinet that the authorization is environmentally sound and that KRS Chapter 350 and 405 KAR Chapter 5 have been satisfied.

Section 28. Permit Conditions; Permit Term. (1) Permits issued by the cabinet may contain certain conditions necessary to ensure that the mineral operation shall be conducted in compliance with KRS Chapter 350 and 405 KAR Chapter 5.
(2) All mineral operations shall be conducted in accordance with KRS Chapter 350 and 405 KAR Chapter 5 conditions of the permit.
(3) Each permit shall be issued for a fixed term not to exceed five (5) years.

Section 29. Denial of a Permit for Past Violations. (1) A mineral operator or person whose permit has been revoked or suspended shall not be eligible to receive another permit or begin another mineral operation, or be eligible to have suspended permits or mineral operations reinstated until he has complied with all applicable requirements of KRS Chapter 350 and 405 KAR Chapter 5 with respect to all permits issued him.
(2) A mineral operator or person whose surface coal mining operation permit has been revoked or suspended shall not be eligible to receive another permit or begin another mineral operation, or be eligible to have suspended permits or mineral operations reinstated until he has complied with all applicable requirements of KRS Chapter 350, 405 KAR Chapters 1, 3, and 7 through 24 with respect to all surface coal mining operation permits issued him.
(3) A mineral operator or person who has forfeited any bond filed with the cabinet for a mineral operation or surface coal mining operation shall be eligible to receive another permit or begin another mineral operation unless:
(a) The land for which the bond was forfeited has been reclaimed without cost to the state; or
(b) The mineral operator or person has paid a sum determined
by the cabinet after the Division of Abandoned Mine Lands has prepared an estimate of the cost to reclaim the lands, based upon site specific conditions.

(4) If the applicant, mineral operator, agent, subcontractor, or agent of a person acting on behalf of the applicant, has either conducted activities with a demonstrated pattern of willful violations of 405 KAR Chapter 5, or has repeatedly been in noncompliance of this chapter, then the permit application shall be denied. A [however, a] mineral permittee shall not be relieved of responsibility with respect to a [any] permit issued to him.

(5) If the cabinet determines that an activity of the applicant regulated pursuant to 405 KAR Chapter 5 is currently in violation of KRS Chapters 149, 151, 224, 350 through 354, 400 KAR Chapters 1 through 3, 401 KAR Chapters 4 through 100, 402 KAR Chapter 3, or 405 KAR Chapters 1 through 30, then the cabinet shall require the applicant, before the issuance of the permit, to either:

(a) Submit proof that [which] can be substantiated by the cabinet that the violation has been corrected, or is in the process of being corrected in good faith;

(b) Establish, by proof that can be substantiated by the cabinet, that the applicant has filed and is presently pursuing, a good faith administrative or judicial appeal to contest the validity of the violation.

(6) If the applicant submits the proof specified pursuant to [under] subsection (5) of this section, then the cabinet may issue the permit with an appropriate condition that either the reclamation work be continued in good faith until completion or that if the applicant loses his action contesting the violation that the violation be corrected within a specified time. Failure to comply with a condition shall be grounds for revocation of the permit.

(7) If the applicant disagrees with the cabinet’s determination pursuant to [under] this section, then he or she has the right to request an administrative hearing pursuant to 405 KAR 5:995.

Section 30. Permit Conference and Public Comment. (1) Procedures for requests. A [Any] person whose interests are or may be adversely affected by the issuance of the application, including the officer or head of any federal, state or local government agency or authority, may request that the cabinet hold an informal conference on the [any] application for a permit. The request shall:

(a) Briefly summarize the issues to be raised by the requester at the conference; and

(b) Be filed with the cabinet within fifteen (15) days of the newspaper advertisement.

(2)(a) The conference shall be held at the Division of Reclamation and Enforcement[Field Services].

(b) The conference shall be held within fifteen (15) days of the date of the request. The date, time, and location of the conference shall be sent to the applicant and parties requesting the conference.

(c) The conference shall be conducted by a representative of the cabinet who shall accept oral or written statements and any other relevant information from a person party to the conference.

(d) If all parties requesting the conference stipulate agreement before the requested conference and withdraw their requests, the conference shall not be held.

(e) All comments and evidence shall be taken into consideration by the Division of Reclamation and Enforcement[Division of Field Services] in Frankfort before a final decision is made on the disposition of the application.

(f) The record shall be maintained and shall be accessible to the parties during the life of the mineral operation.

(3) A [Any] person whose interests are or may be adversely affected by the issuance of the application, including the officer or head of a federal, state, or local government agency or authority, may submit written comments to the cabinet.

Section 31. Existing Mineral Operations. (1) Existing mineral operations that were not permitted or regulated prior to February 1995 are incorporated by reference:

Since the effective date of this administrative regulation, an existing distance limitation was made prior to February 1995 (the effective date of this administrative regulation) by an existing mineral operation that was not permitted or regulated prior to February 1995 (the effective date of this administrative regulation). These variances shall only be granted if [where] practical and reasonable remedial compliance measures cannot be identified.

The distance limitations established in those permits shall continue to apply.

Section 32. Incorporation by Reference. (1) This material is incorporated by reference. “Application for Surface Disturbance Permit Noncoal Mining, NCR-2,” March, 1990, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Natural Resources, #2 Hudson Hollow, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

LEONARD K. PETERS, Secretary
APPROVED BY AGENCY: October 25, 2012
FILED WITH LRC: October 29, 2012 at 2 p.m.
CONTACT PERSON: Michael Mullins, Registration Coordinator,
#2 Hudson Hollow, Frankfort, Kentucky 40601, phone (502) 564-6940, fax (502) 564-5698, email Michael.Mullins@ky.gov.

JUSTICE AND PUBLIC SAFETY CABINET
Department of Corrections
(As Amended at ARRS, January 7, 2013)


RELATES TO: KRS Chapters 196, 197, 439

STATUTORY AUTHORITY: KRS 196.035, 197.020, 439.470, 439.640

NECESSITY, FUNCTION, AND CONFORMITY: KRS 196.035, 197.020, 439.470, 439.590, and 439.640 authorize the Justice and Public Safety Cabinet and Department of Corrections to promulgate administrative regulations necessary and suitable for the proper administration of the department or its divisions. These policies and procedures are incorporated by reference in order to comply with the accreditation standards of the American Correctional Association. This administrative regulation establishes the policies and procedures for the Kentucky State Penitentiary.

Section 1. Incorporation by Reference. (1) Kentucky State Penitentiary policies and procedures, January 7, 2013[November 19, 2012][December 12, 2006], are incorporated by reference.

Kentucky State Penitentiary policies and procedures include:

KSP 01-02-01 Public Information and Media Communications (Amended 11/8/2005)
KSP 02-01-02 Inmate Canteen (Amended 11/8/2005)
KSP 02-02-12 Inmate Funds (Amended 11/14/12[10/12/06])
KSP 03-01-02 Tobacco Free (Amended 11/14/12[11/12/06])
KSP 05-01-02 Inmate Master Records (Amended 11/14/12[12/06])
KSP 10-02-01 Special Management Unit Operating Procedures, Living Conditions and Classification (Amended 11/14/12[12/06])
KSP 10-02-05 Death Row (Amended 12/12/06)
KSP 10-04-01 Special Needs Inmates (Amended 11/14/12[12/06])
KSP 13-02-01 Health Services (Amended 11/8/2005)
KSP 13-02-03 Continuity of Care (Amended 12/12/06)
KSP 13-02-04 Levels of Care and Staff Training (Amended 11/8/2005)
KSP 13-02-05 Consultations (Amended 9/14/2005)
KSP 13-02-08 Health Records (Amended 12/12/06)
KSP 13-02-09 Psychiatric and Psychological Services (Amended 11/8/2005)
KSP 13-02-13 Optometric Services (Amended 9/14/2005)
KSP 14-03-01 Marriage of Inmates (Amended 9/22/2005)
KSP 14-04-01 Legal Services (Amended 9/14/2005)
KSP 14-06-01 Inmate Telephone Access (Amended 9/11/2005)
KSP 15-06-01 Adjustment Procedures (Amended 9/14/2005)
KSP 16-01-01 Visiting Program (Amended 9/14/2005)
KSP 16-02-01 Inmate Correspondence (Amended 9/14/2005)
KSP 16-03-02 Inmate Telephone Access (Amended 11/8/2005)
KSP 16-04-01 Inmate Packages (Amended 9/22/2005)
KSP 17-01-01 Inmate Personal Property (Amended 9/14/2005)
KSP 17-01-02 Disposition of Unauthorized Property (Amended 9/14/2005)
KSP 17-01-03 Procedures for Providing Clothing, Linens and Other Personal Items (Amended 9/14/2005)
KSP 17-01-04 Property Room, Clothing Storage and Property Inventory Control (Amended 11/8/2005)
KSP 17-02-01 Inmate Reception and Orientation (Amended 9/14/2005)
KSP 18-01-01 General Guidelines and Functions of the Classification Committee (Amended 9/14/2005)
KSP 18-10-01 Preparole Progress Report (Amended 9/14/2005)
KSP 18-15-01 Protective Custody Unit (Amended 9/14/2005)
KSP 19-04-01 Inmate Work Programs and Safety Inspections of Inmate Work Locations (Amended 9/12/00)
KSP 19-04-02 Unit Classification Committee and Inmate Work Assignments (Amended 9/14/2006)
KSP 19-05-01 Correctional Industries (Amended 9/14/2005)
KSP 20-04-01 Educational Programs (Amended 11/14/2002)
KSP 22-04-01 Arts and Crafts Programs (Amended 12/12/06)
KSP 23-01-03 Religious Services (Amended 9/14/2005)
KSP 25-01-01 Release Preparation Program (Amended 11/14/2005)
KSP 25-10-01 Discharge of Inmates by Shock Probation (Amended 11/14/2005)

This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of Legal Services, Justice and Public Safety Cabinet, Department of Corrections, 275 E. Main Street, P.O. Box 2400, Frankfort, Kentucky 40602-2400, Monday through Friday, 8 a.m. to 4:30 p.m.

LADONNA H. THOMPSON, Commissioner
APPROVED BY AGENCY: November 7, 2012
FILED WITH LRC: November 14, 2012 at 1 p.m.
CONTACT PERSON: Amy V. Barker, Assistant General Counsel, Department of Justice & Public Safety Cabinet, 125 Holmes Street, Frankfort, Kentucky 40601, phone (502) 564-3279, fax (502) 564-6686.

EDUCATION AND WORKFORCE DEVELOPMENT CABINET
Kentucky Board of Education
Department of Education
(As Amended at ARRS, January 7, 2013)

FILED WITH LRC: November 14, 2012 at 1 p.m.

701 KAR 5:110. Use of local monies to reduce unmet technology need.

STATUTORY AUTHORITY: KRS 156.070, 156.160

NECESSITY, FUNCTION, AND CONFIRMATION: KRS 156.160

(1)(b) requires the Kentucky Board of Education to promulgate administrative regulations governing the acquisition and use of educational equipment for the schools as recommended by the Council for Education Technology. KRS 156.670(1) requires the development of the master plan for education technology to outline Commonwealth activities related to the purchase, development, and use of technology. The master plan requires a district to submit a plan and report which describes its educational initiatives that have technology components and their unmet technology need. KRS 157.655 stipulates that a local public school district may participate in the education technology funding program based on the unmet technology need described in the local district plan and approved by the Kentucky Board of Education (state board). Based on review of the unmet technology need, it has been determined that full implementation of the Kentucky Education Technology System (KETS) cannot be funded based solely on offers of assistance from the Education Technology Trust Fund. Therefore, this administrative regulation establishes the requirements governing the use of local monies to reduce unmet technology need as promulgated to ensure that all school district technology procurements, in categories for which KETS standards for unmet need have been established, will reduce the unmet technology need regardless of source of funds.

Section 1. Definitions. (1) "Department" means the Kentucky Department of Education.

(2) "District education technology plan" means the plan developed by the local school district to address the unmet technology needs of the district.

(3) "Kentucky Education Technology System" or "KETS" means the statewide system set forth in the technology master plan issued by the Kentucky Board of Education and approved by the Legislative Research Commission.

(4) "Master plan" means the long-range plan for the implementation of the Kentucky Education Technology System approved by the Kentucky Board of Education and the Legislative Research Commission.

(5) "Unmet technology need" means the total cost of technology, meeting or exceeding the criteria established in the master plan, needed to achieve the capabilities outlined in the approved district education technology plan of the local school district.

Section 2. Determination of Unmet Need. A local school district shall determine its unmet technology need as part of the education technology planning process. Unmet technology need shall be audited by the department and subject to the approval of the Kentucky Board of Education as part of the state review and assistance calculation process, as provided by the master plan.

Section 3. Reducing Unmet Need. (1) In categories of unmet technology need, as provided in the 2013-2018 KETS Master Plan for Education Technology, a district shall limit procurements to those which will reduce unmet technology need until the district's unmet technology need no longer exists.

(2) The department shall assist districts in selecting equipment, software, and services which will reduce the unmet technology need. To assist a district in selecting technology which will reduce the unmet technology need, the Department of Education shall develop suggested procurement guidelines for equipment, software, and services.

Section 4. Alternative Technology. For technology components
for which KETS standards have not been established, a local school district may propose alternative technologies (waivers) in the local district education technology plan, particularly if the technology is proposed to achieve innovation. The department shall respond to the waiver within a three (3) week period. If denied, the local school district may appeal to the Commissioner of Education.


(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, from the Office of Knowledge, Information and Data Services, Office of Education Technology, 15 Fountain Place, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. through 4:30 p.m.

TERRY HOLLIDAY, Ph.D., Commissioner of Education
DAVID KAREM, Chairperson
APPROVED BY AGENCY: November 15, 2012
FILED WITH LRC: November 15, 2012 at 11 a.m.
CONTACT PERSON: Kevin C. Brown, General Counsel, Kentucky Department of Education, First Floor, Capital Plaza Tower, 500 Meri Street, Frankfort, Kentucky 40601, phone (502) 564-4474, fax (502) 564-9321.

EDUCATION AND WORKFORCE DEVELOPMENT CABINET
Kentucky Board of Education
Department of Education
(As Amended at ARRS, January 7, 2013)

VOLUME 39, NUMBER 8 – FEBRUARY 1, 2013


RELATES TO: KRS 156.070, 156.160, 160.380
STATUTORY AUTHORITY: KRS 156.070, 156.160[—156.070]
NECESSITY, FUNCTION, AND CONFORMITY: KRS 156.070

Section 1. Definitions. (1) “Alternative education program” is defined by KRS 160.380(1)(a).

(2) “Child with a disability” means a child evaluated in accordance with 707 KAR 1:300, as meeting the criteria listed in the definitions in 707 KAR 1:002 for autism, deaf-blindness, developmental delay, emotional-behavioral disability, hearing impairment, mental disability, multiple disabilities, orthopedic impairment, other health impairment, specific language impairment, traumatic brain injury, or visual impairment which has an adverse effect on the child’s educational performance and who, as a result, needs special education and related services.

(3) “Individual education program” or “IEP” means a written statement for a child with a disability that is developed, reviewed, and revised in accordance with 707 KAR 1:320[—156.070] as defined by 707 KAR 1:002.

(4)“ILP” “Individual learning plan” or “ILP” means a comprehensive framework for advising students in grades six (6) through twelve (12) to engage in coursework and activities that will best prepare them to both realize college and career success and become contributing members of their communities.

(5) “Individual learning plan addendum” or “ILPA” means an action plan that addresses the changed educational needs of a student based upon entry into or exit from an alternative education program that includes, as appropriate, academic and behavioral needs of the student, criteria for the student’s re-entry into the traditional program, and provisions for regular review of the student’s progress throughout the school year while in an alternative education program.

(6) “Involuntary placement” means the placement of a student in an alternative education program by local district personnel.

(a) To ensure the safety of the individual student, the student body, or staff;

(b) To meet the educational needs of the student;

(c) To transition the student to a placement as a state agency child pursuant to KRS 158.135 and 505 KAR 1:080; or

(d) For disciplinary purposes; and

(b) Not made at the request of the parent or emancipated student.

(7) “Off-site program” means an alternative education program located in a separate and dedicated program facility not located within the student’s assigned school.

(8) “On-site program” means an alternative education program located within the student’s assigned school.

(9) “Voluntary placement” means the placement of a student in an alternative education program at the request of the parent or emancipated student and with the agreement of school personnel to better meet the educational needs of the student.

Section 2. General Requirements. (1)(a) A district’s[Districts] shall ensure that each alternative education program:

1. Aligns [programs are aligned] with college and career readiness outcomes; and

2. Is [for all students, Districts shall] strive to ensure that alternative education programs are not limited in scope or design; and

3. Includes training to build capacity of staff and administrators to deliver high-quality services and programming that will ensure with best practices and include best practices in training of staff and administrators for delivering services and programming to guide all students to college and career readiness [to one type of program offering to students].

(b) A student[Students] enrolled in an alternative education program[programs] may be eligible to participate in one (1) or more types of programs to address student learning needs that may include an alternative digital learning environment[environments], credit recovery, or an [and] innovative path[paths] to graduation.

(2) Each local board[boards] of education shall adopt and annually review[review and adopt] policies and procedures[as necessary] for the operation of each alternative education program[programs] within the district. Locally-adopted policies and procedures shall include the:

(a) Purpose of the program, including the ways the program supports the district’s college and career readiness goals for students;

(b) Eligibility criteria, as appropriate;

(c) Process for entering students into the program;

(d) Process for transitioning students out of the program;

(e) Composition of the team to develop the ILPA, which shall include an invitation to the parents to participate and, as appropriate, an invitation to the student to participate; and

(f) Procedures for collaboration with outside agencies involved with involuntary placements, including courts or other social service agencies to address student transitions between programs.

(3) An alternative education program shall[programs may] be either an on-site program or an off-site program[programs at the student’s assigned school or off-site programs located in a separate facility].

(4) Alternative education program curriculum shall be aligned with the Kentucky Core Academic Standards established in 704 KAR 3:030, and the student learning goals in the ILP.

(5) Each alternative education program[students] shall be subject to the minimum graduation requirements established in 704 KAR 3:030 and any additional local district graduation requirements.

(6) An alternative education program[programs] shall be subject to any applicable requirements of 703 KAR 5:225 and Kentucky’s Elementary and Secondary Education Act Flexibility Waiver, or its successor.
Section 3. Placement of Students. (1)(a) The placement of students by the district in an alternative education program shall be either voluntary or involuntary.

(b) A student entering an alternative education program shall meet the eligibility requirements for the program established by the local board pursuant to Section 2 of this administrative regulation.

(c) The district shall ensure that an ILP, as required by 704 KAR 3:305, exists prior to placement of a student in an alternative education program.

(2)(a) The placement decision for all students with an IEP shall be made through the admissions and release committee (ARC) pursuant to KAR 7:1320.

(b) For a child with a disability as defined by 707 KAR 4:002, Section 1(9), the IEP shall address the changed educational delivery needs of the student based upon entry into or exit from an alternative education program.

(c) The placement decisions for a student who has an alternative education plan shall use the statewide financial management system and chart of accounts to track costs and expenditures associated with each alternative education program operating in the district.

Section 4. Costs and Expenditures. Each district shall utilize the student information system to enter data regarding each student enrolled in an alternative education program.

Section 5. Data. (1) Each district shall utilize the student information system to enter data regarding each student enrolled in an alternative education program.

(2) Data collected shall include demographic, programmatic, or other data fields contained in the student information system or required by the department to track and report student participation, educational programming, achievement, and transition to and from alternative education programs.

Section 6. Personnel. Alternative education program teachers and administrators shall be subject to the teacher certification requirements established in KRS 161.020, and shall comply with the classified and certified assignment restrictions established in KRS 160.380(3).

TERRY HOLLIDAY, Ph.D., Commissioner of Education

APPROVED BY AGENCY: December 14, 2012

FILED WITH LRC: December 14, 2012

CONTACT PERSON: Kevin C. Brown, General Counsel, Cabinet for Health and Family Services, Department of Education, First Floor, Capital Plaza Tower, 500 Mero Street, Frankfort, Kentucky 40601, phone (502) 564-4474, fax (502) 564-9321.

CABINET FOR HEALTH AND FAMILY SERVICES
Office of Health Policy
(As Amended at ARRS, January 7, 2013)


RELATES TO: KRS 216B.010, 216B.015, 216B.095, 216B.455, 216B.990

STATUTORY AUTHORITY: KRS 194A.030, 194A.050, 216B.040(2)(a)(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.040(2)(a)(1) requires the cabinet for Health and Family Services to administer Kentucky's Certificate of Need Program and to promulgate administrative regulations as necessary for the program. This administrative regulation establishes the requirements necessary for consideration for nonsubstantive review of applications for the orderly administration of the Certificate of Need Program.
those beds.

2. If neonatal Level II beds are relocated or transferred pursuant to this paragraph:
   a. The receiving hospital shall have an existing licensed Level II or Level III neonatal unit;
   b. A minimum of four (4) beds shall be relocated; and
   c. The relocation shall not leave the transferring hospital with less than four (4) neonatal Level II beds unless the relocated beds represent all of its neonatal Level II beds;

(d) The proposal involves an application by an existing licensed hospital to:
   1. Convert psychiatric beds licensed for use with geriatric patients to acute care beds, not including special purpose acute care beds such as neonatal Level II beds or neonatal Level III beds;
   2. Convert and implement the beds on-site at the hospital’s existing licensed facility; and
   3. Delicense the same number of psychiatric or chemical dependency beds that are converted;

(e) The proposal involves an application by an existing licensed hospital providing inpatient psychiatric treatment to:
   1. Convert psychiatric beds licensed for use with geriatric patients to acute care beds, not including special purpose acute care beds such as neonatal Level II beds or neonatal Level III beds;
   2. Convert and implement the beds on-site at the existing licensed hospital; and
   3. Delicense the same number of converted psychiatric beds;

(f) The proposal involves an application by a psychiatric hospital to convert licensed geriatric, adult, adolescent, or child psychiatric beds to psychiatric beds and the requirements established in this paragraph are met.
   1. The psychiatric hospital is located within twenty (20) miles of a United States military base;
   2. The psychiatric hospital provides inpatient behavioral health services to active duty military personnel, families of active duty military personnel, and veterans;
   3. The psychiatric hospital shall convert and implement the beds on-site at the existing licensed hospital; and
   4. The psychiatric hospital shall delicense the same number of converted beds.

(g) The proposal involves an application to transfer or relocate existing certificate of need approved nursing facility beds between certificate of need approved nursing facilities or from a certificate of need approved nursing facility to a proposed nursing facility and the requirements established in this paragraph are met.
   1. The selling or transferring facility has a certificate of need nursing facility bed inventory of at least 250 beds; and
   2. The transfer or relocation takes place within the same Area Development District;
   3. The application includes:
      a. A properly completed OHP - Form 9, Notice of Intent to Acquire a Health Facility or Health Service, incorporated by reference in 900 KAR 6:055; and
      b. Evidence of the selling or transferring entity’s binding commitment to sell or transfer upon approval of the application; and
   4. A certificate of need approved nursing facility shall not sell or transfer more than fifty (50) percent of its certificate of need approved nursing facility beds;

(h) The proposal involves an application to establish a therapeutic cardiac catheterization program and the requirements established in this paragraph are met.
   1. The applicant is an acute care hospital which was previously granted a certificate of need to participate in a primary angioplasty pilot project and was evaluated after the first two (2) years of operation by an independent consultant who determined the hospital successfully demonstrated good therapeutic cardiac catheterization outcomes.
   2. The applicant shall document that the nursing and technical catheterization laboratory staff are experienced and participate in a continuous quality assurance program.
   3. The applicant shall document that the catheterization laboratory shall be equipped with optimal imaging systems, resuscitative equipment, and intra-aortic balloon pump support.
   4. The applicant shall document that the cardiac care unit nurses shall be proficient in hemodynamic monitoring and intra-aortic balloon pump management.
   5. The applicant shall document formalized written protocols in place for immediate and efficient transfer of patients to an existing licensed cardiac surgical facility.
   6. The applicant shall document a Digital Imaging and Communications in Medicine (DICOM) standard image transfer system between the hospital and the backup surgical facility.
   7. The applicant shall employ an interventional program director who has performed more than 500 primary PCI procedures and who is board certified by the American Board of Internal Medicine in interventional cardiology.
   8. The applicant shall document that each cardiologist performing the therapeutic catheterizations shall perform at least seventy-five (75) PCIs per year.
   9. The applicant shall document the ability to perform at least 200 interventions per year, with an ideal minimum of 400 interventions per year by the end of the second year of operation.
   10. The applicant shall participate in the American College of Cardiology National Cardiovascular Data Registry quality measurement program.
   11. The applicant shall report therapeutic cardiac catheterization data annually to the Cabinet for Health and Family Services.
   12. The application shall document the applicant’s ability to produce therapeutic cardiac catheterization outcomes which are within two (2) standard deviations of the national means for the first two (2) consecutive years;

(i) The proposal involves an application to transfer or relocate existing certificate of need approved nursing facility beds from one (1) long-term care facility to another long-term care facility and the requirements established in this paragraph are met.
   1. The selling or transferring facility fails to meet regulations promulgated by the Centers for Medicare and Medicaid Services at 42 C.F.R. 483.70(a)(8) requiring nursing facilities to install sprinkler systems throughout their buildings;
   2. The selling or transferring facility may sell or transfer portions of its total bed component to one (1) or more existing nursing facility;
   3. The facility acquiring the beds shall be located in a county contiguous to that of the selling or transferring facility;
   4. The selling or transferring facility shall be licensed only for nursing facility beds at the time of transfer or application to transfer and shall not sell or transfer more than thirty (30) of its licensed nursing facility beds to an individual facility; and
   5. The application shall include a properly completed OHP - Form 9, Notice of Intent to Acquire a Health Facility or Health Service, incorporated by reference in 900 KAR 6:055;

(j) The proposal involves an application to re-establish a licensed healthcare facility that was provided at a hospital with fifty (50) or fewer licensed beds (the healthcare facility) and which was voluntarily discontinued by the applicant under the following circumstances:
   1. The termination or [j] voluntary closure of the hospital [former healthcare service or facility];
      a. Was not the result of an order or directive by the cabinet, governmental agency, judicial body, or other regulatory authority;
      b. Did not occur during or after an investigation by the cabinet, governmental agency, or other regulatory authority;
      c. Did occur while the facility was in substantial compliance with applicable administrative regulations and was otherwise eligible for re-licensure; and
      d. Was not an express condition of any subsequent Certificate of Need approval;
   2. The application to re-establish the healthcare facility or service that was voluntarily discontinued is filed no more than one (1) year from the date the hospital last provided the service which the applicant is seeking to re-establish [the proposed healthcare service shall be provided within the same geographic service area as the former healthcare service];
   a. A [j] proposed healthcare facility shall be located within the same county as the former healthcare facility and at a single location; and
   4. The application shall not seek to re-establish any type of bed utilized in the care and treatment of patients for more than twenty-three (23) consecutive hours; or
2. The proposed ambulatory surgical center shall utilize the surgical facilities of an existing licensed ambulatory surgical center during times the host ambulatory surgical center is not in operation.

(3)(a) A Certificate of Need approved for an application submitted under subsection (2)(k) of this section shall state the limitations specified under subsection (2)(k), and 2. of this section.

(4)(a) If an application is denied nonsubstantive review status by the Office of Health Policy, the application shall automatically be placed in the formal review process.

(5)[(4)] If an application is granted nonsubstantive review status by the Office of Health Policy, notice of the decision to grant nonsubstantive review status shall be given to the applicant and all known affected persons.

(6)[(5)](a) If an application is granted nonsubstantive review status by the Office of Health Policy, any affected person who believes the applicant is not entitled to nonsubstantive review status or who believes that the application should not be approved may request a hearing by filing a request for a hearing within ten (10) days of the notice of the decision to conduct nonsubstantive review.

(b) The provisions of 900 KAR 6:090 shall govern the conduct of all nonsubstantive review hearings.

(c) Nonsubstantive review applications shall not be comparatively reviewed but may be consolidated for hearing purposes.

(7)[(6)] If an application for certificate of need is granted nonsubstantive review status by the Office of Health Policy, there shall be a presumption that the facility or service is needed and an application for certificate of need shall not be reviewed for consistency with the State Health Plan.

(8)[(7)] Unless a hearing is requested pursuant to 900 KAR 6:090, the Office of Health Policy shall approve each application for a certificate of need that has been granted nonsubstantive review status if:

(a) The application does not propose a capital expenditure; or

(b) The application does propose a capital expenditure, and the Office of Health Policy finds the facility or service with respect to which the capital expenditure proposed is needed, unless the cabinet finds that the presumption of need provided for in subsection (7) of this section has been rebutted by clear and convincing evidence by an affected party.

(9)[(8)] The cabinet shall disapprove an application for a certificate of need that has been granted nonsubstantive review if the cabinet finds that:

(a) Applicant is not entitled to nonsubstantive review status; or

(b) Presumption of need provided for in subsection (7) of this section has been rebutted by clear and convincing evidence by an affected party.

(10)[(9)] A decision to approve or disapprove an application which has been granted nonsubstantive review status shall be rendered within thirty-five (35) days of the date that nonsubstantive review status has been granted.

(11)[(10)] If a certificate of need is disapproved following nonsubstantive review, the applicant may:

(a) Request that the cabinet reconsider its decision pursuant to KRS 216B.090 and 900 KAR 6:095; or

(b) Request that the application be placed in the next cycle of the formal review process; or

(c) Seek judicial review pursuant to KRS 216B.115.

ERIC FRIEDLander, Acting Executive Director
AUBREy TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 7, 2012
FILED WITH LRC: December 12, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40621, phone (502) 564-7905, fax (502) 564-7573.
(5) "Child with a severe emotional disability" is defined by KRS 200.530(2).
(6)(12)2. Social worker; or
3. Direct care staff person; and
4. Which shall not be subcontracted.
(2) "Department" means the Department for Medicaid Services or its designee.
(7)(55) "Diagnostic and assessment services" means at least one (1) face-to-face specially evaluation or specially evaluation performed via telemedicine of a recipient's medical, social, and psychiatric status provided by a physician or qualified mental health professional that shall:
(a) Include:
1. Interviewing and evaluating; or
2. Testing and interviewing; and
(b) Be documented and recorded all contact with the recipient and other interviewed individuals; and
(c) Result in a:
1. Medical data(Diagnosis) code in accordance with 45 C.F.R. 162.1000; and
2. Specific treatment recommendation.
(8)(65) "Federal financial participation" is defined by 42 C.F.R. 400.203.
(9)(2) "Intensive treatment services" means a program:
(a) For a child:
1. With a severe emotional disability; and
b. A severe and persistent aggressive behavior intellectual disability;
2. A severe and persistent aggressive behavior;
2. A developmental disability;
and
(b) Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy.
(c) The person:
1. Is eligible for and receiving Medicaid
2. Direct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;
3. An individual with a minimum of a bachelor's degree in a mental health related field;
3. A registered nurse; or
4. A licensed practical nurse with at least one (1) year's experience in a psychiatric inpatient or residential treatment setting for children;
(b) An individual with:
1. A high school diploma or an equivalence certificate; and
2. At least two (2) years work experience in a psychiatric inpatient or residential treatment setting for children[is defined by KDR C 20.320];
(16)(14) "Physician" is defined by KRS 311.550(12).
(17)(15) "Private psychiatric hospital" is defined by KRS 205.339(2).
(18) "Psychiatric residential treatment facility" or "PRTF" is defined by KRS 216B.450(5).
(19)(16) "Psychiatric services" means:
(a) An individual psychiatric evaluation of a recipient which shall include:
1. A review of the recipient's:
   a. Personal history;
   b. Family history;
   c. Physical health;
   d. Prior treatment; and
   e. Current treatment;
2. A mental status examination appropriate to the age of the recipient;
3. A meeting with the family or any designated significant person in the recipient's life; and
4. Ordering and reviewing:
   a. (b) Laboratory data; or
   b. (ii) Psychological testing results; or
   c. (iii) Any other ancillary health or mental health examination;
(b) Development of an initial plan of treatment which shall include:
1. Prescribing and monitoring of psychotropic medications; or
2. Providing and directing therapy to the recipient;
(c) Implementing, assessing, monitoring, or revising the treatment as appropriate to the recipient's psychiatric status;
(d) Providing a subsequent psychiatric evaluation as appropriate to the recipient's psychiatric status; and
(e) Consulting, if determined to be necessary by the psychiatrist responsible for providing or overseeing the recipient's psychiatric services, with another physician, an attorney, police, school staff, a treatment program staff, or other organization's staff regarding the recipient's care and treatment; or
and
(f) Ensuring that the psychiatrist responsible for providing or overseeing the recipient's psychiatric services has access to the information referenced in paragraph (e) of this subsection.
(1)(19)(i).
(12) shall be:
(a) Provided in accordance with 42 C.F.R. 440.230;
3. A licensed practical nurse with at least one (1) year's experience in a psychiatric inpatient or residential treatment setting for children;
(b) Provided in accordance with 42 C.F.R. 440.230;
3. A licensed practical nurse with at least one (1) year's experience in a psychiatric inpatient or residential treatment setting for children;
3. A licensed practical nurse with at least one (1) year's experience in a psychiatric inpatient or residential treatment setting for children;
3. A licensed practical nurse with at least one (1) year's experience in a psychiatric inpatient or residential treatment setting for children; and
(c) Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 1396d(r) and 42 C.F.R. Part 441 Subpart B for Medicaid-eligible persons under twenty-one (21) years of age.
(5) "Psychiatric residential treatment facility" or "PRTF"
"Review agency" means a review, evaluation, or authorization decision regarding an individual who is:

(a) Not enrolled with a managed care organization:

1. The department; or
2. An entity under contract with the department; or
(b) Enrolled with a managed care organization:

1. The managed care organization with which the enrollee is enrolled; or
2. An entity under contract with the managed care organization with which the enrollee is enrolled; or
(c) Department if the Medicaid recipient is not enrolled in a managed care organization; or
(d) Entity under contract with the department if the Medicaid recipient is not enrolled in a managed care organization.

"State mental hospital" is defined by KRS 205.639(3).

"Telemedicine" means two-way, real time interactive communication between a patient and a physician or practitioner located at a distant site for the purpose of improving a patient's health through the use of telecommunication equipment, in addition to audio and video equipment [the use of electronic information and telecommunication technologies to support long-distance clinical health care].

"Treatment plan" means a plan created for the care and treatment of a recipient that:

(a) Is developed in a face-to-face meeting by the recipient's interdisciplinary team; and
(b) Describes a comprehensive, coordinated plan of medically necessary behavioral health services that specifies a modality, frequency, intensity, and duration of services sufficient to maintain the recipient in a PRTF setting; and
(c) Identifies:

1. A program of therapies, activities, interventions, or experiences designed to accomplish the plan;
2. Interventions by caregivers in the PRTF and school setting that support the recipient's ability to be maintained in a PRTF setting;
3. Behavioral, social, and physical problems with interventions and objective, measurable goals;
4. Discharge criteria for each of the requested services that specifies the:
   a. Recipient-specific behavioral indicators for discharge from the service;
   b. Expected service level that would be required upon discharge; and
   c. Identification of the intended provider to deliver services upon discharge;
5. A crisis action plan that progresses through a continuum of care that is designed to reduce or eliminate the necessity of inpatient services;
6. A plan for:
   a. Transition to a lower intensity of services; and
   b. Discharge from PRTF services;
7. An individual behavior management plan;
8. A plan for the involvement and visitation of the recipient with the birth family, guardian, or other significant person, unless prohibited by a court, including therapeutic off-site visits pursuant to the treatment plan; and
9. Services and planning, beginning at admission, to facilitate the discharge of the recipient to an identified plan for home-based services or a lower level of care; and

Section 2. Provider Participation. (1)(a) In order to participate, or continue to participate, in the Kentucky Medicaid Program, a Level I PRTF shall:

1. Have a utilization review plan for each recipient consisting of, at a minimum, a pre-admission certification review submitted via telephone or electronically to the review agency prior to admission of the recipient;
2. Perform and place in each recipient's record:
   a. A medical evaluation;
   b. A social evaluation; and
   c. A psychiatric evaluation;
3. Establish a plan of care for each recipient which shall be placed in the recipient's record;
4. Submit a utilization review committee which shall:
   a. Oversee and implement the utilization review plan; and
   b. Evaluate each Medicaid admission and continued stay prior to the expiration of the Medicaid certification period to determine if the admission or stay is or remains medically necessary;
5. PRTF shall:
   (a) Have a utilization review plan which complies with 907 KAR 1:016; and
   b. Appoint a utilization review committee which complies with 907 KAR 1:016;

(b) In order to participate, or continue to participate, in the Kentucky Medicaid Program, a Level II PRTF shall:

1. Have a utilization review plan for each recipient;
2. Establish a utilization review process which shall evaluate each Medicaid admission and continued stay prior to the expiration of the Medicaid certification period to determine if the admission or stay is or remains medically necessary;
3. Comply with staffing requirements established in 902 KAR 20:320;
4. Be located in the Commonwealth of Kentucky;
5. Maintain accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Council on Accreditation of Services for Families and Children or any other accrediting body with comparable standards that is recognized by the state; and
6. Comply with all conditions of Medicaid provider participation established in 907 KAR 1:671 and 907 KAR 1:672;

(2) (a) A pre-admission certification review:
   (a) for a Level I PRTF shall:
   1. Contain:
      a. The recipient's valid Medicaid identification number;
      b. A valid MAP-569, Certification of Need by Independent Team Psychiatric Preadmission Review of Elective Admissions for Kentucky Medicaid Recipients Under Age Twenty-One (21) which satisfies the requirements of 42 C.F.R. 44.152 and 42 C.F.R. 441.153 for patients age twenty-one (21) and under;
      c. A DSM IV R diagnosis on all five (5) axes, except that failure to record an axis IV or V diagnosis shall be used as the basis for a denial only if those diagnoses are critical to establish the need for Level I PRTF treatment;
   d. A description of the initial treatment plan relating to the admitting symptoms;
(1) The recipient's valid Medicaid identification number;
(2) A valid MAP-569, Certification of Need by Independent Team Psychiatric Preadmission Review of Elective Admissions for Kentucky Medicaid Recipients Under Age Twenty-One (21) which satisfies the requirements of 42 C.F.R. 441.152 and 42 C.F.R. 441.153 for patients age twenty-one (21) and under;
(c) A DSM-IV-R diagnosis on all five (5) axes, except that failure to record an axis IV or (and) V diagnosis shall be used as the basis for a denial only if those diagnoses are critical to establish the need for Level II PRTF treatment;
(d) Documentation of the initial treatment plan relating to the admitting symptom;
(e) Current symptoms requiring inpatient treatment;
(f) Information to support the medical necessity and clinical appropriateness of the services or benefits of the admission to a Level II PRTF in accordance with 907 KAR 3:130;
(g) Medication history;
(h) Prior hospitalization;
(i) Prior alternative treatment;
(j) Appropriate medical, social, and family histories; and
(k) Proposed aftercare placement;
(2) Remain in effect for the days certified by the review agency; and
(3) Be completed within thirty (30) days:
(a) A completed MAP-569, Certification of Need for Inpatient Psychiatric Services for Individuals Under Age Twenty-One (21), and the form shall be placed in the recipient’s medical record.
(b) Document the need for admission and appropriate utilization of services; and
(c) Document the need for admission and appropriate utilization of services; current, readily retrievable, organized, complete, legible, and shall reflect sound medical recordkeeping practice in accordance with 42 C.F.R. 441.152 and 42 C.F.R. 441.153, and the form shall be placed in the recipient’s medical record.
(4) For a recipient, a Level I or II PRTF shall maintain medical records that shall:
(a) Be;
1. Current;
2. Readily retrievable;
3. Organized;
4. Complete; and
5. Legible;
(b) Reflect sound medical recordkeeping practice in accordance with:
1. 902 KAR 20:320;
2. KRS 194A.060;
3. KRS 434.840 through 860;
4. KRS 422.317; and
5. 42 C.F.R. 431 Subpart F;
(c) Document the need for admission and appropriate utilization of services; and
(d) Document the need for admission and appropriate utilization of services; and
(e) Show that the recipient was receiving intensive treatment services in accordance with 907 KAR 1:016;
(f) Be maintained in an organized central file, including information regarding payments claimed, for a minimum of six (6) years or until an audit dispute or issue is resolved, whichever is longer; and
(g) Be made available for inspection or copying or provided to the following upon request:
1. A representative of the United States Department for Health and Human Services or its designee;
2. The United States Office of the Attorney General or its designee;
3. The Commonwealth of Kentucky, Office of the Attorney General or its designee;
4. The Commonwealth of Kentucky, Office of the Auditor of Public Accounts or its designee;
5. The Commonwealth of Kentucky, Cabinet for Health and Family Services, Office of the Inspector General or its designee;
6. The department; and
7. A managed care organization with whom the department has contracted if the recipient is enrolled with the managed care organization.

Section 3. Covered Admissions. (1) A covered admission for
Section 4. PRTF Covered Services. (1)(a) There shall be a
1. The amount and frequency of services needed; and
2. The number of therapeutic pass days for a recipient, if
the treatment plan includes any therapeutic pass days.
(2) and Coverage Criteria.
1. To be covered by the department:
(a) The following services shall be available to a recipient
covered under Section 3 of this administrative regulation
[prior authorized and shall meet the requirements established in paragraph (b) of this subsection:
1. Diagnostic and assessment services;
2. Treatment plan development, review, or revision;
3. Psychiatric services;
4. Nursing services which shall be provided in compliance with 902 KAR 20:320;
5. Medication which shall be provided in compliance with 907 KAR 1:019;
6. Evidence-based treatment interventions;
7. Individual therapy which shall comply with 902 KAR 20:320;
8. Family therapy or attempted contact with family which
shall comply with 902 KAR 20:320;
9. Group therapy which shall comply with 902 KAR 20:320;
10. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
11. Substance abuse education which shall comply with 902 KAR 20:320;
12. Activities that:
(a) Support the development of an age-appropriate daily living
skill including positive behavior management or support; or
(b) Support and encourage the parent’s ability to re-integrate
the child into the home;
13. Crisis intervention which shall comply with:
  a. 42 C.F.R. 483.350 through 376; and
  b. 902 KAR 20:320;
14. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
15. Educational activities; or
16. Non-medical transportation services as needed to accomplish objectives;
(b) A Level I PRTF service listed in paragraph (a) of this subsection shall be:
1. Provided under the direction of a physician;
2. If included in the recipient’s treatment plan, described in the recipient’s current treatment plan;
3. [Provided at least once per week, except for diagnostic and assessment services which shall have no weekly minimum requirement;]
4. Medically necessary; and
5. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
(c) A Level II PRTF service listed in subparagraph (a), (8), 9, 11, or 13 shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
(d) A Level II PRTF service listed in paragraph (a) of this subsection shall be:
1. Provided under the direction of a physician;
2. If included in the recipient’s treatment plan, described in the recipient’s current treatment plan;
3. Provided at least once a week;
   a. Unless the service is necessary twice a week, in which case, the service shall be provided at least twice a week; or
   b. Except for diagnostic and assessment services which shall have no weekly minimum requirement;
4. Medically necessary; and
5. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.

(3) (2) A Level II PRTF service listed in subparagraph (a), (8), 9, 11, or 13 shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.

Section 5. Determining Patient Status. (1) The department shall review and evaluate the health status and care needs of a recipient in need of Level I or II PRTF care using the criteria identified in 907 KAR 3:130 to determine if a service or benefit is clinically appropriate.
(2) The care needs of a recipient shall meet the patient status criteria for:
(b) Level I PRTF care if the recipient requires:
1. A child with a severe emotional disability;
2. Requires long term inpatient psychiatric care or crisis stabilization more suitablely provided in a PRTF than in a psychiatric hospital;
3. Level I PRTF services on a continuous basis as a result of a severe mental or psychiatric illness, including a severe emotional disturbance;
(b) Level II PRTF care if the recipient requires:
1. Is a child with a severe emotional disability;
2. Requires long term inpatient psychiatric care or crisis stabilization more suitablely provided in a PRTF than in a psychiatric hospital;
3. Requires Level II PRTF services on a continuous basis as a result of a severe emotional disability in addition to a severe and persistent aggressive behavior, an intellectual disability, a sexually acting out behavior, or a developmental disability; and
4. Does not meet the medical necessity criteria for an acute care hospital or a psychiatric hospital which cannot be met in an ambulatory care setting, Level I PRTF, or in any other less restrictive environment.

Section 6. Durational Limit, Re-evaluation, and Continued Stay. (1) A recipient’s stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department’s approval.
(2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria established in...
Section 5(2) of this administrative regulation.
(b) A Level I PRTF shall complete a review of each recipient's treatment plan [of care shall] at least once every thirty (30) days.
(c) The review referenced in paragraph (b) of this subsection shall include:
1. Dated signatures of:
   a. Appropriate staff; and
   b. If present for the treatment plan meeting, a [dated signature of a] parent, guardian, legal custodian, or conservator;
2. An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
3. A statement of justification for the level of services needed including:
   a. Suitability for treatment in a less-restrictive environment; and
   b. Continued services.
(d) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual’s current approved stay.
(e) The review referenced in paragraph (a) of this subsection shall be performed by a review agency:
1. A review agency if the recipient is not enrolled with a managed care organization; or
2. A managed care organization or entity under contract with a managed care organization in which the recipient is enrolled if the recipient is enrolled in a managed care organization.
(f) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:
1. Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;
2. An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
3. A statement of justification for the level of services needed including:
   1. Suitability for treatment in a less-restrictive environment; and
   2. Continued services.
(g) For a recipient aged four (4) to five (5) years, a Level II PRTF shall complete a review of the recipient’s treatment plan of care at least once every fourteen (14) days after the initial review referenced in subsection (3) of this section.
(h) The review referenced in paragraph (a) of this subsection shall include:
1. Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;
2. An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
3. A statement of justification for the level of services needed including:
   a. Suitability for treatment in a less-restrictive environment; and
   b. Continued services.

Section 7 shall be:
(1) Preauthorized;
(2) Limited to those for children age six (6) through twenty (20) years of age who meet Medicaid payment status criteria. Coverage may continue, based on medical necessity, for a recipient who is receiving active treatment in a PRTF on his 21st birthday so long as he has not reached his 22nd birthday; and
(3) Reimbursed in accordance with 907 KAR 9:010.

Section 4. Durational Limitations. Recipient stays shall be subject to utilization review by the cabinet.

Section 5. Determining Patient Status. (1) The department shall review and evaluate the health status and care needs of a recipient in need of inpatient psychiatric care using the same standards as established for inpatient psychiatric hospital care in 907 KAR 1:016.
(2) The care needs of a recipient shall meet PRTF patient status criteria only if:
   (a) The individual meeting the patient status criteria in 907 KAR 1:016 requires long-term inpatient psychiatric care or crisis stabilization more suitably provided in a PRTF rather than a psychiatric hospital; and
   (b) The recipient requires PRTF services on a continuous basis as a result of a severe mental or psychiatric illness, including severe emotional disturbances.

Section 6. Reevaluation of Need for Services. Patient status shall be reevaluated for a PRTF recipient at thirty (30) day intervals. If a reevaluation reveals the recipient no longer requires PRTF care, payment shall continue only through the last day for which the stay is certified.

Section 7. Exclusions and Limitations in Coverage. (1) The following shall not be covered as Level I or II PRTF services:
   (a) Chemical dependency treatment services if the need for the services is the primary diagnosis of the recipient, except that chemical dependency treatment services shall be covered as incidental treatment if minimal chemical dependency treatment is necessary for successful treatment of the primary diagnosis;
   (b) Outpatient services;
   (c) Pharmacy services, which shall be covered as pharmacy services in accordance with 907 KAR 1:019.
   (d) Durable medical equipment, which shall be covered as a durable medical equipment benefit in accordance with 907 KAR 1:479;
   (e) Hospital emergency room services, which shall be covered in accordance with 907 KAR 10:014;
   (f) Acute care hospital inpatient services, which shall be covered in accordance with 907 KAR 10:012;
   (g) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.
   (h) Dental services, which shall be covered in accordance with 907 KAR 1:026;
   (i) Hearing and vision services, which shall be covered in accordance with 907 KAR 1:038;
   (j) Ambulance services, which shall be covered in accordance with 907 KAR 1:060.
(2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.
(3) The department shall not reimburse for Level I or II PRTF services for a recipient. Services shall not be covered if appropriate alternative services are available for the recipient in the community.
(4) The following shall not qualify as reimbursable in a PRTF setting for a PRTF recipient:
   (a) An admission that is not medically necessary;
   (b) Services for an individual;
   1. With a major medical problem or minor symptoms;
   2. [An individual to whom] an individual who might only require a psychiatric consultation rather than an admission to a PRTF[; psychiatric facility]; or
   3. [An individual who might need only adequate living accommodations, economic aid, or social support services.]

Section 8. Reserved Bed and Therapeutic Pass Days. (1)(a) The department shall have the power to reserve beds in a psychiatric hospital for an acute patient who comes in from a Level I or II PRTF:
1. If the recipient:
   1. Has been in the Level I or II PRTF overnight for at
Section 9. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

1. Stated in the recipient’s treatment plan; and
2. Approved by the recipient’s treatment team.

(4)(a) A review agency if the decision is regarding a recipient who is not enrolled with a managed care organization; or
(4)(b) A managed care organization or an entity under contract with a managed care organization to perform authorization reviews if the decision is regarding a recipient who is enrolled with a managed care organization.

(5)(a) An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRFT due to receiving psychiatric treatment in an acute care hospital;
(5)(b) A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital reserve day shall count as an absence for census purposes.

(c) An admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.

Section 9. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies or does not provide federal financial participation for the policy; or
(2) Disapproves the policy. The department shall cover reserve bed days in accordance with the following specified upper limits and criteria:

(1) Upper limits for reserved beds shall be applied as follows:
(a) A maximum of fourteen (14) days per admission for an acute care hospital stay;
(b) A maximum of fourteen (14) days per calendar year for an admission to a mental hospital or a psychiatric bed in an acute care hospital;
(c) A maximum of twenty-one (21) days per six (6) months during a calendar year for other leaves of absence; and
(d) A maximum of thirty (30) consecutive days for hospital and other leaves of absence combined.

(2) The following criteria shall be met for reserved bed days to be covered:
(a) The recipient shall be in Medicaid payment status in a Level I or II PRFT;
(b) The recipient shall be reasonably expected to return to PRFT level of care;
(c) Due to the demand at the facility for PRFT care, there is likelihood the bed would be occupancy percent is at least fifty (50) percent.
(d) A maximum of thirty (30) consecutive days for hospital and other leaves of absence combined.

(3) The department shall allow a recipient to exceed the limit established in paragraph (b) of this subsection if the department determines that an additional bed reserve day is in the best interest of the recipient.

(4) An authorization decision regarding a bed reserve day or therapeutic pass day in excess of the limits established in this section shall be performed by a review agency.

(5)(a) An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRFT due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital;
(b) A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital reserve day shall count as an absence for census purposes.

(c) An absence from a Level I or II PRFT that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or a therapeutic pass day count for each recipient shall begin at zero (0) on January 1 of the calendar year.

(6) The annual bed reserve day limit per recipient [per Level I or II PRFT] shall be five (5) days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital.

The following criteria shall be met for reserved bed days to be covered:
(a) The recipient shall be in Medicaid payment status in a Level I or II PRFT;
(b) Has not exceeded the bed reserve day limit established in paragraph (b) of this subsection;
(c) Is reasonably expected to return requiring Level I or II PRFT care; and
(d) Has not exceeded the therapeutic pass day limit established in paragraph (c) of this subsection.

(6)(b) The annual bed reserve day limit per recipient [per Level I or II PRFT] shall be fourteen (14) days per calendar year.

The following criteria shall be met for reserved bed days to be covered:
(a) Is in Medicaid payment status in a Level I or II PRFT;
(b) Is reasonably expected to return requiring Level I or II PRFT care; and
(c) Due to the demand at the facility for PRFT care, there is likelihood the bed would be occupied by some other patient, if it had not been reserved.

(7) Supervision of the administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

1. The department shall cover a therapeutic pass day count for each recipient shall begin at zero (0) upon the effective date of adoption of this administrative regulation.
2. For subsequent calendar years, the bed reserve day and therapeutic pass day count for each recipient shall begin at zero (0) on January 1 of the calendar year.
3. An authorization decision regarding a bed reserve day or therapeutic pass day in excess of the limits established in this section shall be performed by a review agency.
4. An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRFT due to receiving psychiatric treatment in an acute care hospital;
5. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital reserve day shall count as an absence for census purposes.
6. An absence from a Level I or II PRFT that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or a therapeutic pass day count for each recipient shall begin at zero (0) upon the effective date of adoption of this administrative regulation.
7. A Level I or II PRFT’s occupancy percent shall be at least fifty (50) percent.
8. The Level I or II PRFT’s occupancy percent is at least fifty (50) percent.
9. Is in Medicaid payment status in a Level I or II PRFT;
10. Has not exceeded the bed reserve day limit established in paragraph (b) of this subsection; and
11. Is in Medicaid payment status in a Level I or II PRFT; and
12. Is reasonably expected to return requiring Level I or II PRFT care; and
13. Has not exceeded the therapeutic pass day limit established in paragraph (c) of this subsection.
14. The bed reserve day and therapeutic pass day count for each recipient shall be zero (0) upon the effective date of adoption of this administrative regulation.
15. For subsequent calendar years, the bed reserve day and therapeutic pass day count for each recipient shall begin at zero (0) on January 1 of the calendar year.
16. An authorization decision regarding a bed reserve day or therapeutic pass day in excess of the limits established in this section shall be performed by a review agency.
17. An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRFT due to receiving psychiatric treatment in an acute care hospital;
18. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital reserve day shall count as an absence for census purposes.
19. An absence from a Level I or II PRFT that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or a therapeutic pass day count for each recipient shall begin at zero (0) upon the effective date of adoption of this administrative regulation.
VOLUME 39, NUMBER 8 – FEBRUARY 1, 2013

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Healthcare Facilities Management
(As Amended at ARRS, January 7, 2013)


RELATES TO: KRS 205.520, 216B.450, 216B.455, 216B.459
NECESSITY, FUNCTION, AND CONFORMITY: [EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds for the provision of medical assistance to Kentucky’s indigent citizenry. This administrative regulation establishes Medicaid reimbursement policies for Level I and Level II psychiatric residential treatment facility services provided to a Medicaid recipient who is not enrolled in a managed care organization and both required and optional reimbursement policies for Level I and Level II psychiatric residential treatment facility services provided to a Medicaid recipient who is enrolled in a managed care organization. A managed care organization may elect to reimburse for Level I and Level II psychiatric residential treatment facility services in accordance with this administrative regulation if the managed care organization so chooses. The reimbursement policies established in this administrative regulation shall not apply to a managed care organization, except the requirement that a Level I or II PRTF service shall be in accordance with 907 KAR 9:005 in order to be reimbursable under the Medicaid program [sets forth provisions relating to payments for psychiatric residential treatment facility services].

Section 1. Definition. (1) “Department” means the Department for Medicaid Services or its designee.
(2) “Federal financial participation” is defined by 42 C.F.R. 400.203.
(3) “Level I PRTF” means a psychiatric residential treatment facility that meets the criteria established in KRS 216B.450(5)(a).
(4) “Level II PRTF” means a psychiatric residential treatment facility that meets the criteria established in KRS 216B.450(5)(b).
(5) “Managed care organization” means an entity for which the department has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.
(6) “Per diem rate” means a Level I or II PRTF’s total [all-inclusive] daily reimbursement as calculated by the department.
(7) “Recipient” is defined by KRS 205.845(9).

Section 2. Reimbursement for Level I PRTF Services and Costs. (1) To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with 907 KAR 9:005.
(2) The department shall reimburse for Level I PRTF services and costs referenced in subsection (4) of this section for a recipient not enrolled in a managed care organization:
(a) At the lesser of:
   1. A per diem rate of $274.01; or
   2. The usual and customary charge; and
(b) An amount not to exceed the prevailing charges, in the locality where the Level I PRTF is located, for comparable services provided under comparable circumstances.
(3) The per diem rate referenced in subsection (2) of this section shall be increased each biennium by 2.22 percent.
(4) The per diem rate referenced in subsection (2) of this section, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
   (a) Including all care and treatment costs;
   (b) Including costs for all ancillary services;
   (c) Including capital costs;
   (d) Including room and board costs; and
   (e) Excluding the costs of drugs as drugs shall be:
      1. Covered in accordance with 907 KAR 1:019; and
      2. Reimbursed via the department’s pharmacy program in accordance with 907 KAR 1:018.

Section 3. Reimbursement for Level II PRTF Services and Costs. (1) To be reimbursable under the Medicaid Program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with 907 KAR 9:005.
(2) The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:
(a) $345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria established in subsection (3)(a) of this section; rate group one (1) Level II PRTF;
(b) $385 for Level II PRTF services to a recipient who meets the rate group two (2) criteria established in subsection (3)(b) of this section; rate group two (2) Level II PRTF;
(c) $405 for Level II PRTF services to a recipient who meets the rate group three (3) criteria established in subsection (3)(c) of this section; rate group three (3) Level II PRTF;
(d) $405 for Level II PRTF services to a recipient who meets the rate group four (4) criteria established in subsection (3)(d) or (e) of this section; rate group four (4) Level II PRTF.
(3)(a) Rate group one (1) criteria shall be for a recipient who:
   (1) Is Aged twelve (12) years or younger;
   (2) Is male or female; and
   (3) Has an intelligence quotient higher than seventy.
(3)(b) Rate group two (2) criteria shall be for a recipient who:
   (1) Is Aged twelve (12) years or younger;
   (2) Is male or female; and
   (3) Has a severe and persistent aggressive behavior;
   (4) Does Not have mental retardation or a developmental disability; and
   (5) Has an intelligence quotient higher than seventy.
(3)(c) Rate group three (3) criteria shall be for a recipient who:
   (1) Is Aged thirteen (13) years of age or older;
   (2) Is male or female; and
   (3) Has an intelligence quotient higher than seventy.
(3)(d) Rate group four (4) criteria shall be for a recipient who:
   (1) Is Aged thirteen (13) years of age or older;
   (2) Is male or female; and
   (3) Has a severe and persistent aggressive behavior;
   (4) Does Not have mental retardation or a developmental disability; and
   (5) Has an intelligence quotient higher than seventy.
Section 7. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(a) Denies or does not provide federal financial participation for the policy; or
(b) Disapproves the policy.

Section 8. Appeals. A provider may appeal a decision by the department regarding the application of this administrative regulation in accordance with 907 KAR 1.671.

Section 9. Not Applicable to Managed Care Organizations. (1) A managed care organization may elect to reimburse for Level I and II psychiatric residential treatment facility services in accordance with this administrative regulation if the managed care organization so chooses.

(2) The reimbursement policies established in this administrative regulation shall not apply to a managed care organization, except the requirement that a Level I or II PRTF service shall be reimbursable under the Medicaid Program.


(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8:00 a.m. to 4:30 p.m. Psychiatric residential treatment facility (PRTF) means an appropriately licensed PRTF participating in the Medicaid Program.

Section 2. Payment Rates. Covered inpatient psychiatric facility services for individuals under twenty-two (22) years of age provided in PRTFs of sixteen (16) beds or less shall be paid for in accordance with the following:

(a) The PRTFs shall be paid a fixed rate of $800 per diem which shall be adjusted upward each biennium by 2.22 percent; or
(b) The PRTFs shall be paid a fixed rate of $800 per diem which shall be adjusted upward each biennium by 2.22 percent; or a
not exceed prevailing charges in the locality for comparable services provided under comparable circumstances.

2. The fixed rate, or usual and customary charge if less, covers total facility costs for covered PRTF services, excluding the cost of drugs, as follows:
   (a) All care and treatment costs;
   (b) Costs for all ancillary services, excluding the cost of drugs which shall be reimbursed through the pharmacy program;
   (c) Capital costs; and
   (d) Room and board costs.

Section 3. Cost Reports and Audits. PRTF’s shall file a cost report annually using a uniform cost report form prescribed by the Department for Medicaid Services. The cabinet may audit the cost reports as it deems necessary.

Section 4. Access to PRTF Fiscal and Services Records. Access shall be granted to PRTF fiscal and services records to the extent determined necessary by the cabinet, as follows:
   (1) To assure accuracy of the cost report, that services are provided in accordance with the standards shown in this administrative regulation and in 907 KAR 1:505 and
   (2) The PRTF is complying with all terms and conditions of the provider agreement between the cabinet and PRTF.

(3) Representatives of the United States Department of Health and Human Services, Inspector General’s Office, and Attorney General’s Office shall have access to PRTF records to the extent necessary to perform their functions which relate to the Medicaid Program.

Section 5. Implementation Date. The provisions of this administrative regulation shall be applicable for services provided on or after November 1, 1995.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 13, 2012
FILED WITH LRC: December 13, 2012 at noon
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Behavioral Health, Developmental and Intellectual Disabilities
Division for Behavioral Health
(As Amended at ARRS, January 7, 2013)


RELATES TO: KRS 194A.050, 194A.070, 222.221
STATUTORY AUTHORITY: KRS 222.211, 222.231

NECESSITY, FUNCTION, AND CONFORMITY: KRS 222.231 requires the Cabinet for Health and Family Services to promulgate administrative regulations necessary to establish requirements and standards for licensing agencies and approving substance abuse prevention programs. KRS 194A.050 requires the secretary to[shall] promulgate, administer, and enforce those administrative regulations necessary to implement programs mandated by federal law, or to qualify for the receipt of federal funds and necessary to cooperate with other state and federal agencies for the proper administration of the cabinet and its programs. This administrative regulation establishes licensing requirements for substance abuse prevention agencies.

Section 1. Definitions. (1) "Agency" is defined by KRS 222.005(2).
   (2) "Alcohol and other drug abuse" is defined by KRS 222.005(3).
   (3) "Cabinet" is defined by KRS 194A.005.
   (4) "Certified Prevention Specialist" means an individual who is approved by the Kentucky Certification Board of Prevention Professionals.
   (5) "Coalition" means a partnership of volunteers working to reduce alcohol, tobacco, and other drug abuse problems through community-wide prevention strategies.
   (6) "Consumer" means the recipient of prevention services.
   (7) "Department" is defined by KRS 194A.030(4).
   (8) "Early Intervention Program" is a program that helps Kentucky youths under age twenty-one (21) and their families learn about risks and consequences of substance use, the benefits of good health and well-being among youths, and promotes positive decision-making to resist alcohol, tobacco, and other drugs.
   (9) "International Certification and Reciprocity Consortium" or "ICRC" means the organization that establishes the standards of practice in addiction counseling, prevention, and clinical supervision through testing and credentialing of addiction professionals.
   (10) "Kentucky Certification Board for Prevention Professionals" or "KCBPP" means an ICRC member board that establishes competency-based certification for prevention professionals that promotes and maintains integrity and quality of service for alcohol, tobacco, and other drug prevention.
   (11) "Prevention" means the act of preventing problems resulting from alcohol, tobacco, and other drug use.
   (12) "Prevention Director" means a prevention professional who manages Regional Prevention Center staff, serves as liaison between Regional Prevention Center and the department, and is responsible for developing the annual plan and budget documents for the prevention program.
   (13) "Prevention Professional" means a paid staff, excluding clerical staff, employed by a Regional Prevention Center actively involved in the development and implementation of a substance abuse prevention program.
   (14) "Regional Prevention Center" or "RPC" means a program funded by the department for the purpose of developing, providing, and coordinating substance abuse prevention programs and activities in a specified geographical region of the state.
   (15) "Strategic Prevention Framework" or "SPF" means a planning process identified by Substance Abuse Mental Health Service Administration.

Section 2. Licensing Procedures. (1) An agency receiving re-authorization for any prevention program shall not operate without first obtaining an alcohol and other drug prevention license from the cabinet, unless the agency is exempted under KRS 222.003(1) and (2).
   (2) An agency shall be licensed to operate a Regional Prevention Center in accordance with 908 KAR 1:380, Section 2.

An application for a prevention license shall be submitted in writing to the Office of Inspector General, Division of Licensing and Regulation, 275 East Main Street, Frankfort, Kentucky 40621.

The license shall remain in effect for one (1) year from the date of issuance and may be renewed, unless the license has been:
   (a) Revoked;
   (b) Suspended; or
   (c) Modified by the cabinet for a substantial failure to comply with the licensure standards.

(5) The license shall be conspicuously posted in a public area at the agency and shall indicate the year the license was issued or renewed.

(6) An application for licensure or renewal shall include an on-site inspection by the cabinet representatives to determine compliance with licensure standards.

(7) The applicant shall provide the cabinet or its representatives access during normal hours of operation to any document needed to complete the inspection.

(8) The cabinet shall notify the agency in writing within ten (10) calendar days of any violation of licensure standards identified during the inspection.

(9) The agency shall submit to the cabinet a written plan of correction within ten (10) calendar days of receipt of the notice of violation. The correction plan shall specify the corrective action to be taken and the date when each violation shall be corrected.

(10) The certificate of licensure shall be the property of the
cabinet and shall be returned upon closure or revocation of the license.

(11) The cabinet may issue a new license for the remainder of the current licensure period.

(12) Any agency operating a program without first obtaining a license shall be subject to the penalties as stated in KRS 222.990(2).

Section 3. Changes in Agency Status. (1) An agency shall notify the cabinet within ten (10) working days of a change in:

(a) Name;
(b) Location;
(c) Ownership; or
(d) Discontinuance of services.

(2) If there is a change in agency name, ownership, or location, the cabinet may issue a new license for the remainder of the current licensure period.

Section 4. Staffing and Staff Qualifications. (1) A prevention professional shall be certified by the Kentucky Certification Board for Prevention Professionals as an International Certified Prevention Specialist within thirty-six (36) months of:

(a) The effective date of this administrative regulation; or
(b) Initial employment.

(2) The agency shall designate one (1) individual as the prevention director who shall:

(a) Be certified by the KCBPP as an International Certified Prevention Specialist; and

(b) Have a bachelors degree plus five (5) years of work experience in prevention or the related fields of health, social science, marketing, communication, or education; or

(c) Have a masters degree with two (2) years of work experience in prevention administration or administration in the related fields of health, social sciences, marketing, communication, or education.

(3) Staff responsible for providing prevention services within the agency shall be clearly designated.

(4) The agency shall designate an individual to serve as an ombudsman who shall be responsible for responding to:

(a) Staff or consumer complaints; and

(b) Staff or consumer grievances.

Section 5. Regional Prevention Centers. (1) RPC staff shall:

(a) Conduct the following program management functions:

1. Planning;
2. Staffing;
3. Policy development;
4. Program development; and
5. Program evaluation.

(b) Prepare a written mission statement and program operations manuals which shall be reviewed by the prevention director at least one (1) time per year and updated as necessary;

(c) Coordinate and implement all prevention programs, initiatives, and activities funded by the department in the region, with the exception of those specifically exempted by the department;

(d) Coordinate and implement an Early Intervention Program;

(e) Assist communities to develop and implement educational and environmental strategies for adults and children to prevent the:

1. Use of illegal drugs;
2. Abuse of alcohol; and
3. Abuse of other chemicals such as tobacco, pharmaceuticals, and household products that have psychoactive properties;

(f) Collaborate with community agencies and organizations in the provision of prevention services;

(g) Tailor programs to the characteristics of specific target audiences, including age, gender, drug-use pattern, racial, ethnic, and cultural heritage;

(h) Gather and disseminate information about drug-specific prevention activities provided by other agencies, organizations, or individuals within their region;

(i) Participate in mentoring activities and statewide meetings as designated by the department;

(j) Participate in a computerized communication system with the department and other RPCs;

(k) Facilitate cooperation among agencies, groups, and individuals involved in prevention;

(l) Develop, maintain, and sustain regional and county coalitions;

(m) Create forums for coordination and networking of substance abuse prevention professionals; and

(n) Provide consultation with community organizations that wish to develop comprehensive prevention programs.

(2) A Prevention professional working in RPCs shall provide:

(a) Information on subjects relevant to substance abuse prevention;

(b) Professional information to assist community members in acquiring the knowledge necessary for their involvement in prevention efforts;

(c) Resources for use in community prevention programs;

(d) Books, pamphlets, audio visual, and training materials which shall be made available for use by the community; and

(e) Well-defined, structured training and learning experiences including both information and skill development designed to directly influence the drug use behavior of the consumer and incorporate evidence-based and professionally developed curricula. The program shall train:

1. Persons to reach others with prevention information or lead prevention activities in the groups with which they are involved; and

2. Professionals and volunteers in the community to conduct training for others.

(3) RPC staff shall submit schedules of training and other events to the department upon request.

(4) RPC staff shall:

1. Assist or serve only those prevention programs with a primary content that deals specifically with drug use; and

2. Not deliver programs with a primary content aimed at raising self-esteem, increasing general wellness, raising socio-economic status, or similar factors that may be indirectly related to drug abuse.

(5) RPCs may:

(a) Raise community awareness of the need for a comprehensive approach to prevention;

(b) Encourage and assist in community planning for prevention activities;

(c) Provide consultation and training for providers of prevention programs;

(d) Raise community awareness of the need for intervention and recovery programs as part of a comprehensive approach to prevention;

(e) Encourage and assist in community planning for intervention and recovery activities; and

(f) Provide consultation and training for providers of intervention and recovery programs.

(6) RPC staff shall not provide intervention and recovery programs for persons who are in need of substance abuse treatment.

Section 6. Department Responsibilities. The department shall:

(1) Conduct on-site visits to:

(a) Review program progress and compliance; and

(b) Conduct random record checks for accuracy and validity.

(2) Review and approve budgets and quarterly reports to ensure accuracy and efficiency in spending;

(3) Review training plans for RPC staff; and

(4) Ensure adherence to the Strategic Prevention Framework to include:

(a) Assessment;

(b) Building capacity;

(c) Planning;

(d) Implementation;

(e) Evaluation;

(f) Sustainability; and

(g) Cultural competence.

STEPHEN HALL, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: November 8, 2012
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Child Care
(As Amended at ARRS, January 7, 2013)


STATUTORY AUTHORITY: KRS 194A.050(1), 199.896(2), (6) NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the Secretary of the Cabinet for Health and Family Services to promulgate administrative regulations necessary to operate programs and fulfill the responsibilities vested in the cabinet, for the receipt of federal funds, and cooperate with other state and federal agencies for the proper administration of the cabinet and its programs. KRS 199.896(2) authorizes the cabinet for Health and Family Services to promulgate administrative regulations to establish license fees and standards for a child-care center. KRS 199.896(6) requires the cabinet to establish an informal dispute resolution process. This administrative regulation establishes licensure standards for a child-care center and describes the informal dispute resolution process.

Section 1. Definitions. (1) "Address check" means a cabinet search of the Sex Offender Registry to determine if a person’s residence is a known address of a registered sex offender.
(2) "Cabinet" is defined by KRS 199.894(1).
(3) "Child" is defined by KRS 199.011(4) [and may include a minor]:
(a) Thirteen (13) years of age; or
(b) Eighteen (18) years of age if the minor has a special need for which supervision is required.
(4) "Child-care center" is defined by KRS 199.894(3).
(5) "Licensee" means the owner and operator of a child-care center to include:
(a) Sole proprietor;
(b) Corporation;
(c) Limited liability company;
(d) Partnership;
(e) Association; or
(f) Organization, such as:
1. Board of education;
2. Private school;
3. Faith-based organization;
4. Government agency; or
5. Institution.
(6) "Developmentally appropriate" means suitable for the specific age range of the child.
(5) "Nontraditional hours" means the hours of:
(a) 7:00 a.m. through 5:00 p.m. Monday through Friday; or
(b) 7:00 a.m. on Friday until 5:00 a.m. on Monday.
(7) "Parent" is defined by 45 C.F.R. 98.2.
(8) "Premises" means the building and contiguous property in which child care is provided.
(9) "Secretary" is defined by KRS 199.011(1).
(10) "Sex Offender Registry" means the registration system for adults who have committed sex crimes or crimes against minors established in accordance with KRS 17.500 through 17.580.

Section 2. Child-care Centers. The following child-care centers shall meet the requirements of this administrative regulation:
(1) A Type I child-care center. This child-care center shall be licensed to regularly provide child care services for:
(a) Four (4) or more children in a nonresidential setting; or
(b) Thirteen (13) or more children in a designated space separate from the primary residence of a licensee; and
(2) A Type II child-care center. This child-care center shall be primary residence of the licensee in which child care is regularly provided for seven (7), but not more than twelve (12), children including children related to the licensee.

Section 3. Exempt Child Care Settings. The following child-care settings shall be exempt from licensure requirements of this administrative regulation, 922 KAR 2:110, and 922 KAR 2:120:
(1) Summer camps certified by the cabinet as youth camps which serve school-age children;
(2) Kindergarten through grade 12 in private schools while school is in session;
(3) All programs and preschools regulated by the Kentucky Department of Education governed by KRS Chapter 157;
(4) Summer programs operated by a religious organization which a child attends no longer than two (2) weeks;
(5) Child care provided while parents are on the premises, other than the employment and educational site of parents;
(6) Child care programs operated by the armed services located on an armed forces base;
(7) Child care provided by educational programs that include parental involvement with the care of the child and the development of parenting skills;
(8) Facilities operated by a religious organization while religious services are being conducted; and
(9) A program providing instructional and educational programs:
(a) That operates for a maximum of twenty (20) hours per week; and
(b) Which a child attends for no more than ten (10) hours per week.

Section 4. Application. (1) An applicant for a license shall submit to the cabinet a completed OIG-DGCC-01. Child-Care Center License Application[OIG-RCC-1. Application for a License to Operate a Child Care Center].
(2) The issuance or reapproval of a license shall be governed under the provisions of Sections 4 through 7(6) of this administrative regulation.
(3) If the applicant for licensure is a:
(a) Corporation or a limited liability company, the application shall include a current certificate of existence or authorization from the Secretary of State; or
(b) Partnership, the application shall include:
1. A written statement from each partner assuring that the partnership is current and viable; and
2. Proof that each individual is twenty-one (21) years or older by photo identification or birth certificate.
(4) If the status of a corporation, partnership, or ownership of the child-care center changes, the new entity shall submit a completed OIG-DGCC-01[OIG-RCC-1].
(5) If ownership of a child-care center changes and the cabinet approves licensure upon inspection of the child-care center under the new ownership, the effective date on the license shall be the date of the approved inspection under the new ownership.
(6) A child may include a person eighteen (18) years of age if the person has a special need for which child care is required.

Section 5. Evacuation Plan. (1) A licensed child-care center shall have a written evacuation plan in the event of a fire, natural disaster, or other threatening situation that may pose a health or safety hazard for a child in care in accordance with KRS 199.895.
(2) The cabinet shall post an online template of an evacuation plan that:
(a) Fulfills requirements of KRS 199.895;
(b) Is optional for a child-care center’s use[completion]; and
(c) Is available to a licensed child-care center without charge.

Section 6. License Issuance. (1) A license shall not be issued unless each background check required by KRS 199.896(19) has been completed on behalf of an applicant for licensure.
(2) A director, employee, volunteer, or any person with supervisory or disciplinary control over, or having unsupervised contact with, a child shall:

(a) Submit to background checks described in paragraph (b) of this subsection.

(b) [and (a)] May be employed or work with a child on a probationary basis for up to ninety (90) calendar days, pending completion of:
1. Child abuse or neglect check using the central registry in accordance with 922 KAR 1:470; and
2. Criminal records check required by KRS 199.896(19).
3. Criminal records check for any previous state of residence if the person resided outside the state of Kentucky in the last five (5) years;
4. An address check of the Sex Offender Registry; and
(c) [h] Shall not be left alone in the presence of a child until copies of the background checks in accordance with paragraph (b) of this subsection have been received by the licensee if each request for background check, background check, or criminal records check described in subsection (2)[(b)(ae) of this section, a licensee shall discharge immediately a director, employee, volunteer, or any person:
   (a) Whose name is listed on the central registry established by 922 KAR 1:470; or
   (b) Who has been convicted of a crime in accordance with KRS 17.165;
   (c) Who is confirmed by an address check of the Sex Offender Registry and supporting document as a registered sex offender; or
   (d) Who has been convicted of a drug-related felony, and five (5) years has not elapsed since the person was fully discharged from imprisonment, probation, parole, or any other criminal jurisdiction.

(3) Upon completion of background checks, a child abuse or neglect check or criminal records check described in subsection (2)[(b)(ae)] of this section, a licensee shall be immediately discharged a director, employee, volunteer, or any person:
   (a) Whose name is listed on the central registry established by 922 KAR 1:470; or
   (b) Who has been convicted of a crime in accordance with KRS 17.165;
   (c) Who is confirmed by an address check of the Sex Offender Registry and supporting document as a registered sex offender; or
   (d) Who has been convicted of a drug-related felony, and five (5) years has not elapsed since the person was fully discharged from imprisonment, probation, parole, or any other criminal jurisdiction.

(4) An applicant who has been convicted of a nonviolent felony or misdemeanor shall be handled on a case-by-case basis with consideration given to:
   (a) Nature of the offense;
   (b) Length of time that has elapsed since the event; and
   (c) Applicant’s life experiences after conviction.

(5) If an applicant for licensure has had a prior certification, license, registration, or permit denied, revoked, or suspended for one (1) of the reasons set forth in KRS 199.896(19) or Section 11(2)(10)(c) of this administrative regulation.

(6) If a license is granted after the three (3) year period specified in subsection (5)(a) of this section (paragraph (a) of this subsection), the licensee shall serve a two (2) year probationary period during which the child-care center shall be inspected on at least a quarterly basis.

(7) A license shall specify:
   (a) A particular premises[physical location];
   (b) A designated licensee(sponsor or owner as operator);
   (c) Age category of the children in care;
   (d) The maximum number of children allowed under center supervision at one (1) time, including a child related to the licensee or an employee, based upon:
   1. Available space as determined by the State Fire Marshal’s Office in conjunction with the cabinet;
   2. Adequacy of program;
   3. Equipment; and
   4. Staff;
   (e) If provided, nontraditional hours;
   (f) If provided, transportation; and
   (g) A list of services to be provided by the child-care center.

(8) To qualify for and maintain a license, a child-care center shall:
   (a) Provide written documentation from the local authority showing compliance with local zoning requirements;
   (b) Be approved by the Office of the State Fire Marshal or designate;
   (c) Have an approved water and sewage system in accordance with local, county, and state laws;
   (d) Have adequate equipment, supplies, and staff to serve initial enrollment of children;
   (e) Provide written proof of liability insurance coverage of at least $100,000 per occurrence;
   (f) Comply with provisions of this administrative regulation, 922 KAR 2:110, and 922 KAR 2:120;
   (g) Cooperate with the state agency during an investigation of an alleged complaint, including an allegation of child abuse or neglect pursuant to KRS 620.030(4)(3) and 2. Unannounced cabinet inspections; and
   (h) Have a director who meets the requirements listed in 922 KAR 2:110.

(9) A child-care center shall allow the cabinet or its designee and parent or an enrolled child unannounced access to the child-care center during the hours of operation.

(10) A license shall be issued and reapproved if the center has met the requirements contained in this administrative regulation, 922 KAR 2:110, 922 KAR 2:120, and KRS 199.896(3), (13), (15), (16), (18), and (19).

(11) A license shall not be sold or transferred.

(12) Changes to a child-care center as listed in 922 KAR 2:110, Section 6(4), (5), and (6) shall be:
   (a) In writing to the cabinet or its designee; and
   (b) Signed by each owner listed on the license.

(13) The cabinet or its designee shall not charge a fee for acting upon reported changes.

(14) The license shall be posted in a conspicuous place in the child-care center.

(15) A child-care center shall not begin operation without a license to operate from the cabinet.

(16) A child-care center operating without a license shall be subject to legal action.

Section 7[6]. Fees. (1) A nonrefundable licensing fee of fifty (50) dollars shall be charged according to KRS 199.896(3).

(2) Licensing fees shall be:
   (a) Payable to the Kentucky State Treasurer;
   (b) Attached to the licensure application; and
   (c) Paid by:
   1. Cashier’s[1] [Cashier’s] check;
   2. Certified check; or
   3. Money order.

Section 8[2]. Annual Reapproval. (1) A licensee seeking reapproval shall:
   (a) Submit, one (1) month prior to license expiration, an OIG-DRCC-01 [OIG-DRCC-2, Application for Renewal of a License to Operate a Child Care Center]; and
   (b) Meet the requirements specified in Sections 4 through 7[6] of this administrative regulation.

(2) An application for renewal shall be denied in accordance with Section 11 of this administrative regulation.

Section 9[8]. Statement of Deficiency and Corrective Action Plans. (1) If a center is found not to be in regulatory compliance, the cabinet or its designee shall complete a written statement of deficiency in accordance with KRS 199.896(5).

(2) Except for a violation posing an immediate threat as handled in accordance with KRS 199.896(5)(c), a child-care center shall submit a written corrective action plan to the cabinet or its designee within ten (10) calendar days of receipt of the statement of deficiency to eliminate or correct the regulatory violation.

(3) A corrective action plan shall include:
(a) Specific action undertaken to correct a violation;
(b) The date action was or shall be completed; and
(c) Action utilized to assure ongoing compliance.
(4) The cabinet or its designee shall review the plan and notify the child-care center within thirty (30) calendar days of receipt of the plan, in writing, of the decision to:
(a) Accept the plan;
(b) Not accept the plan; or
(c) Deny, suspend, or revoke the child-care center’s license, in accordance with Section 11[14] of this administrative regulation.
(5) A notice of unacceptability shall state the specific reasons the plan is unacceptable.
(6) A child-care center notified of the unacceptability of its plan shall:
(a) Within ten (10) calendar days of notification, submit an amended plan; or
(b) Have its license revoked or denied for failure to submit an acceptable amended plan in accordance with KRS 199.896(4).
(7) Following two (2) unacceptable plans of correction, in a forty-five (45) calendar day period, the cabinet may deny or revoke an application for licensure or license.
(8) The administrative regulatory violation reported on a statement of deficiency that poses an immediate threat to the health, safety, or welfare of a child shall be corrected within five (5) working days of notification in accordance with KRS 199.896(5)(c).

Section 10[9]. Intermediate Sanctions. (1) If the cabinet determines that a child-care center is in violation of this administrative regulation, 922 KAR 2:110, or 922 KAR 2:120, the cabinet may, based on the severity of the violation:
(a) Require the provider to participate in additional training;
(b) Increase the frequency of monitoring by cabinet staff;
(c) Enter into an agreement with the provider detailing the requirements for remedying a violation and achieving compliance; or
(d) Notify or require the provider to notify a parent of a child who may be affected by the situation for which an intermediate sanction has been imposed.
(2) An intermediate sanction shall result in a suspension or revocation of the license if a child-care center:
(a) Fails to meet a condition of the intermediate sanction; or
(b) Violates a requirement of an intermediate sanction.

Section 11[14]. Basis for Denial, Suspension or Revocation. (1) The cabinet shall deny, suspend, or revoke a license in accordance with KRS 199.896(4) and (19) if the applicant for licensure, director, employee, or a person who has supervisory authority over, or unsupervised[direct] contact with, a child fails to meet the requirements of this administrative regulation or those of 922 KAR 2:110 or 922 KAR 2:120.
(2) For the purposes of KRS 199.896(19), an applicant who has been found by the cabinet to have abused or neglected a child shall mean an individual who is listed on the central registry described in 922 KAR 1:470.

(3) A child abuse or neglect check required by KRS 199.896(19) shall be conducted:
(a) One (1) time; and
(b) Within ninety (90) calendar days of initial employment.
(4) A director, employee, volunteer, any person with supervisory or disciplinary control over, or having unsupervised[direct] contact with, a child shall report to the licensee if:
(a) Convicted of a violent crime or sex crime in accordance with KRS 17.165[defined by KRS 17.165(1) through (3)];
(b) The subject of a child abuse or neglect investigation;
(c) Found by the cabinet or a court to have abused or neglected a child;
(d) Convicted of a drug-related felony, and five (5) years have not elapsed since the person was fully discharged from imprisonment, probation, or parole;
(e) Placed on the Sex Offender Registry; or
(f) Determined by a physician to have a health condition that renders the person unable to care for children.
(4)[(5)] Each licensee shall report to the cabinet or its designee if the licensee, director, employee, volunteer, or another person who submitted to a background check meets a criterion of subsection (3) of this section.
(6)[(2)] Public information shall be provided in accordance with KRS 199.896(10) and (11), and 199.898(2)(d) and (e).
(7) Unless an applicant for a license meets requirements of Section 6(5) of this administrative regulation,[45] the cabinet shall deny an applicant for a license if:
(a) The applicant has been previously denied, suspended, or revoked.
(b) Denial, investigation, or revocation proceedings were initiated, and the licensee voluntarily relinquished the license;
(c) An appeal of a denial, suspension, or revocation is pending;
(d) The applicant previously failed to comply with the requirements of KRS 199.896, 922 KAR 2:110, 922 KAR 2:120, or this administrative regulation;
(e) The applicant is the parent, spouse, sibling, or child of a previous licensee whose license was denied, suspended, or revoked as described in paragraphs (a) through (d) of this subsection, and the previous licensee will be involved in the child-care center in any capacity;
(f) The applicant listed as an officer, director, incorporator, or organizer of a cooperation or limited liability company whose child-care center license was denied, suspended, or revoked as described in paragraph (a) through (d) of this subsection within the past three (3) years;
(8)[(9)] A child-care center’s license shall be revoked if:
(a) A representative of the center interferes with a cabinet representative’s ability to perform an official duty; or
(b) A cabinet representative or parent is denied access to:
1. A child; or
2. The child-care center.
(9)[(10)] The cabinet or its designee shall suspend the license if:
(a) Regulatory violations are found that pose an immediate threat to the health, safety, and welfare of the children in care as described in KRS 199.896(4); or
(b) The child-care center fails to comply with the approved corrective active plan.

Section 12[14]. Civil Penalty. The cabinet shall assess and enforce a civil penalty in accordance with 922 KAR 2:190.[Failure to Pay Civil Monetary Penalty. After sixty (60) calendar days of completing the administrative appeal process, a license shall be denied or revoked when a child-care center fails to:
(1) Pay the civil monetary penalty levied against the center; or
(2) Make arrangements to pay a civil monetary penalty and comply with the arrangement.]
Section 14(43). Informal Dispute Resolution.
(1) A request for informal dispute resolution shall:
(a) Accompany the request for a hearing;
(b) Identify the licensure deficiency in dispute;
(c) Specify whether the applicant for licensure or licensee disagrees with the deficiency; and
(d) Include documentation that disputes the deficiency.
(2) Upon receipt of the written request for informal dispute resolution, the regional program manager or designee shall:
(a) Review documentation submitted by the applicant for licensure or licensee; and
(b) If requested, schedule a first-level informal dispute resolution meeting with the applicant for licensure or licensee.
(3) The first-level informal dispute resolution meeting shall be held within ten (10) calendar days of receipt of the request by the cabinet, unless both parties agree in writing to an extension of time.
(4) The first-level informal dispute resolution meeting shall be conducted by:
(a) The regional program manager or designee; and
(b) A child care surveyor who did not participate in the survey resulting in the disputed deficiency.
(5) Within ten (10) calendar days of completion of the first-level informal dispute resolution meeting or request, the regional program manager or designee shall:
(a) Issue a decision by written notification to the return address specified in the request for informal dispute resolution;
(b) If a change is made to the statement of deficiencies, issue an amended statement of deficiencies; and
(c) Specify whether the adverse action has been rescinded.
(6) An applicant or a licensee may appeal a decision issued by the regional program manager or designee by:
(a) Proceeding with a hearing according to KRS 13B.050; or
(b) Filing a written request for a second-level informal dispute resolution to the Director of the Division of Regulated Child Care or designee within ten (10) calendar days of receipt of the first level decision. The request shall specify whether the applicant for licensure or licensee requests a meeting with cabinet staff.
(7) Upon receipt of the written request for second-level informal dispute resolution, the Director of the Division of Regulated Child Care or designee shall:
(a) Review the decision issued from the first-level informal dispute resolution;
(b) Review the documentation described in subsection (1)(d) of this section; and
(c) If requested, schedule a second-level informal dispute resolution meeting with the applicant for licensure or licensee.
(8) The second-level informal dispute resolution meeting shall be held within ten (10) calendar days of receipt of the request by the cabinet, unless both parties agree in writing to an extension of time.
(9) Within ten (10) calendar days of completion of the second-level informal dispute resolution meeting or request, the Director of the Division of Regulated Child Care or designee shall:
(a) Issue a decision by written notification to the return address specified in the request for second-level informal dispute resolution;
(b) If a change is made to the statement of deficiencies, issue an amended statement of deficiencies; and
(c) Specify whether the adverse action has been rescinded.
(10) If a second-level informal review is requested in lieu of a first-level informal dispute resolution meeting, the Director of the Division of Regulated Child Care or designee shall comply with the provisions of subsection (9)(a) through (c) of this section within ten (10) calendar days of receipt of the request for second-level informal dispute resolution.
(11) If an applicant for licensure or licensee is satisfied with the decision issued during informal dispute resolution, the request for a hearing shall be withdrawn.
(12) If an applicant for licensure or licensee is not satisfied with the decision issued from the second-level informal dispute resolution, the hearing previously held in abeyance shall be conducted in accordance with KRS Chapter 13B concerning the deficiencies that were reviewed in the informal review process.
(13) A request for informal dispute resolution shall not:
(a) Limit, modify, or suspend enforcement action against the applicant for licensure or licensee; or
(b) Delay submission of a written plan of correction.
(14) Emergency action taken in accordance with Section 11(5)(106) of this administrative regulation shall conform to the requirements of KRS 199.896(4). The informal dispute resolution process shall not restrict the cabinet's ability to issue an emergency order to stop, prevent, or avoid an immediate threat to public health, safety, or welfare under KRS 13B.125(2) and 199.896(4).

Section 15(44). Incorporation by Reference. (1) The following material is incorporated by reference:
(a) "OIG-DRCC-01, Child Care Center License Application", edition 8/3/12, and
(b) "OIG-DRCC-02, Licensed Request for Appeal or Informal Dispute Resolution", edition 8/3/12/OIG-RRC-1, Application for a License to Operate a Child Care Center", edition 12/07.
(c) "OIG-RRC-2, Application for Renewal of a License to Operate a Child Care Center", edition 12/07, and
(d) "OIG-RRC-3, Request for Appeal", edition 12/07.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Inspector General's Office, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

TERESA C. JAMES, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: September 13, 2012
FILED WITH LRC: September 13, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Child Care
(As Amended at ARRS, January 7, 2013)

922 KAR 2:100. Certification of family child-care homes.

STATUTORY AUTHORITY: KRS[194A.050(1), 199.8982(1)(f)]
NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the Secretary of the Cabinet for Health and Family Services to promulgate administrative regulations necessary to operate programs and fulfill the responsibilities vested in the cabinet, qualify for the receipt of federal funds, and cooperate with other state and federal agencies for the proper administration of the cabinet and its programs. KRS 199.8982(1)(f) requires the cabinet to promulgate administrative regulations to establish standards for the issuance, monitoring, release of information, renewal, denial, revocation, and suspension of a certificate of operation, and to impose minimum staff-to-child ratios for a family child-care home. The statute authorizes the cabinet to establish minimum safety requirements for operation of a certified family child-care home. This administrative regulation establishes minimum requirements intended to protect the health, safety, and welfare of children cared for by certified family child-care home providers.

Section 1. Definitions. (1) "Address check" means a cabinet search of the Sex Offender Registry to determine if a person's residence is a known address of a registered sex offender.
(2) "Assistant" means a person:
(a) Who meets the requirements listed in Section 2(6)[(4)] and Section 10(9)(7), (8), and (9) of this administrative regulation; and
(b) Whose work is either paid or unpaid.
"Cabinet" is defined by the KRS 199.011(2).

"Child" is defined by KRS 199.011(4) and may include a minor:

(4) "Mental health professional" means a person currently licensed as:
(a) Physician;
(b) Physician's assistant;
(c) Advanced registered nurse or practitioner; or
(d) Registered nurse as defined by KRS 314.011(5) under the supervision of a physician.

"Day care home" is defined by KRS 199.894(5).

"Health professional" means a person currently licensed as a:
(a) Physician;
(b) Physician's assistant;
(c) Advanced registered nurse or practitioner; or
(d) Registered nurse as defined by KRS 314.011(5) under the supervision of a physician.

"Infant" means a child who is less than twelve (12) months of age.

"Parental participation" means a family child-care home's provision of information or inclusion of a child's parent in the child-care home's activities such as:
(a) Distribution of a newsletter;
(b) Distribution of a program calendar;
(c) A conference between the provider and the parent; or
(d) Other activity designed to engage a parent in the program's activities.

"Pediatric abusive head trauma" is defined by KRS 620.020(9).

"Premises" means the building and contiguous property in which child care is provided and certified.

"Preschool-age" means a child who is older than a toddler and younger than school-age.

"Provider" means an owner, operator, or person who:
(a) Cares for a child in the provider's own home;
(b) Is not required to be licensed under 922 KAR 2:090; and
(c) Meets the requirements of Section 2 of this administrative regulation.

"Related" means having one (1) of the following relationships with the provider:
(a) [Child; Grandchild; Niece; Nephew; Sibling; Step-child; or Child in legal custody of the provider.]
(b) School-age child means a child attending kindergarten, elementary, or secondary education.

"Sex Offender Registry" means the registration system for adults who have committed sex crimes or crimes against minors established in accordance with KRS 17.500 through 17.580.

"Toddler" means a child between the age of twelve (12) months and twenty four (24) months.

Section 2. Certification Process. (1) The cabinet or its designee shall be responsible for certifying a family child-care home.

(2) An applicant for certification shall:
(a) Show proof by photo identification or birth certificate that the individual is at least eighteen (18) years of age;
(b) Obtain commercial liability insurance of at least $50,000 per occurrence; and
(c) Submit within ninety (90) days of initiation of the application process:
1. A completed OIG-DRC-03, Certification Application for Family Child Care Home.[OIG-BCC-4, Application for Certified Family Child Care Home].
2. A completed OIG-RCC-6, Self-Check List;
3. A nonrefundable certification fee pursuant to KRS 199.8982(1)(b);
4. Written documentation from the local authority showing the child-care home is in compliance with local zoning requirements;
5. Documentation of the requirements of KRS 199.8982(1)(a) through 3 and 5;
6. A OIG-DRC-04, Certified Family Child-Care Home Central Registry Check.[OIG-BCC-5, Central Registry Check], to complete:
   a. A child abuse or neglect check using the central registry in accordance with 922 KAR 1:470; and
   b. An address check of the Sex Offender Registry;
6. A completed criminal records check required by KRS 17.165(5); and
7. A criminal records check for any previous state of residence completed once if:
   a. The applicant resided outside the state of Kentucky in the last five (5) years; and
   b. No criminal records check has been completed for the applicant's previous state of residence.
7. A copy of the applicant's qualifications and experience and the applicant's statement documenting that the applicant is free of active tuberculosis.

An applicant of a non-violent felony or misdemeanor may be approved on a case by case basis with consideration given to the:
(a) Nature of the offense; and
(b) Length of time that has elapsed since the event; and
(c) Applicant's life experiences after the conviction.

(7) Upon receipt of a completed application for certification, and a nonrefundable certification fee pursuant to KRS 199.8982(1)(b), the cabinet shall:
(a) Review and process the application; and
(b) Conduct an unannounced inspection of the home pursuant to KRS 199.8982(1)(b), including review of the evacuation plan in accordance with Section 18(7) of this administrative regulation.

(8) If the requirements of subsections (1) through (7) of this section, Section 3, and Sections 10 through 12 of this administrative regulation have been met, an applicant shall be certified as described in KRS 199.8982.

(9) Within three (3) months of submission to the cabinet of a
complete OIG-DRCC-03[OIG-RCC-4], an applicant shall:
(a) Demonstrate completion of six (6) hours of cabinet-approved training in accordance with KRS 199.8982(1)(a); and
(b) Develop and implement a written plan for obtaining nine (9) hours of annual cabinet-approved training as required in Section 10[9] through 19[42] of this administrative regulation.

10 A[A family child-care home certificate shall:
(a) Be displayed in a prominent place, as required by KRS 199.8982(1)(c);
(b) Contain:
1. Name and address of the child care provider;
2. Maximum number of unrelated children who may be served; and
3. Identification number; and
4. Effective and expiration date; and
(c) Be valid for only the:
1. Name of the individual authorized on the certificate to operate a family child-care home; and
2. Residential address printed on the certificate.
(1) A change of location shall require:
(a) A ten (10) calendar day notice;
(b) A completed OIG-DRCC-03[OIG-RCC-4];
(c) An inspection of the new home; and
(d) Continued compliance with this administrative regulation.

Section 3. Renewal of Certification. (1) A family child-care certification shall be renewed every two (2) years.
(2) A[A family child-care home provider shall submit one (1) month prior to expiration of the provider's certification:
(a) A completed OIG-DRCC-03[OIG-RCC-4];
(b) A nonrefundable renewal fee pursuant to KRS 199.8982(1)(b);
(c) A physician's statement documenting that the family child-care home provider's health is satisfactory for continued operation of a family child-care home; and
(d) Proof that the family child-care home provider continues to meet the minimum requirements specified in Sections 2, 3, and 10[9] through 19[42] of this administrative regulation.
(3) The cabinet shall:
(a) Review and process the application;
(b) Conduct an unannounced inspection of the home pursuant to KRS 199.8982(1)(b); and
(c) Approve the family child-care home[es] within fifteen (15) calendar days of receipt of the application if the requirements in Sections 2, 3, and 10[9] through 19[42] of this administrative regulation are met.
(4) To the extent funds are available, the cabinet may conduct an unannounced inspection of the home pursuant to KRS 199.8982(1)(b) annually as a condition of certification renewal.

Section 4. Statement of Deficiency and Corrective Action Plans. (1) If the cabinet finds a provider noncompliant with Sections 2, 3, or 10 through 19 of this administrative regulation, the cabinet or its designee shall complete a written statement of deficiency.
(2) Except for a violation posing an immediate threat, a family child-care home shall submit a written corrective action plan to the cabinet or its designee within ten (10) calendar days from receipt of the statement of deficiency to eliminate or correct the regulatory violation.
(3) A corrective action plan shall include:
(a) Specific action undertaken to correct a violation;
(b) The date action was or will be completed; and
(c) Action utilized to assure ongoing compliance.
(4) The cabinet or its designee shall review the plan and notify a family child-care home within thirty (30) calendar days from receipt of a plan, in writing, of the decision to:
(a) Accept the plan;
(b) Not accept the plan; or
(c) Deny, suspend, or revoke the family child-care home's certification in accordance with Section 6, 7, or 8 of this administrative regulation.
(5) A notice of unsatisfactory shall state the specific reasons a plan was not accepted.
(6) A family child-care home notified of an unacceptable plan shall:
(a) Submit an amended plan within ten (10) calendar days of notification; or
(b) Have its certification revoked or denied for failure to submit an acceptable amended plan.
(7) Following two (2) unacceptable plans of correction in a forty-five (45) calendar day period, the cabinet shall deny an application for certification or revoke a provider's certification.
(8) An administrative regulatory violation reported on a statement of deficiency that poses an immediate threat to the health, safety, or welfare of a child shall be corrected by the family child-care home provider within five (5) working days of notification.

Section 5[4]. Denial of Application for Certification. (1) An application for initial certification or renewal of certification as a family child-care home[provider] shall be denied if the applicant, an assistant, or an adult residing in the household has:
(a) Has abused or neglected a child according to a check of the central registry in accordance with 922 KAR 1.470[40];
(b) Has a history of behavior that may impact the safety or security of a child in care including:
1. A criminal conviction of a sex crime or violent crime in accordance[as defined in] KRS 17.165(1) and (3);
2. A conviction for a drug-related felony, and if five years has not elapsed since the person was fully discharged from imprisonment, probation, or parole; or
3. Other behavior or condition indicating inability to provide reliable care to a child; or
(c) Is placed on the Sex Offender Registry.
(2) An application for certification as a family child-care home provider shall be denied if the applicant:
(a) Fails to comply with the minimum certification standards specified in an unacceptable amended plan or other form required by the cabinet or its designee.

(3) Effect of previous denial or revocation.
(a) If an applicant has had a previous child care registration, certification, or license subject to denial, suspension, or revocation for certification has had a prior certificate or license to operate a child care business denied or revoked, the cabinet shall grant the applicant a certificate to operate a family child-care home if:
1. A two (2) year period has expired from the:
   a. Date of the prior denial, suspension, or revocation;
   b. Last day of legal remedies being exhausted; or
   c. Date of the Final Order from an administrative hearing; and
   2. The applicant has:
      a. Demonstrated the ability to comply with the provisions of this administrative regulation and KRS 199.8982;
      b. Completed, since the time of the prior denial or revocation, sixty (60) hours of cabinet-approved training in developmentally appropriate child care practice; and
      c. Not had an application, registration, certificate, or license to operate as a child care provider denied or revoked;

(i) Conviction of a sex crime or violent crime in accordance[as defined in] KRS 17.165(1) and (3); or
(ii) Placement on the Sex Offender Registry;

(iii) Conviction of a drug-related felony, and if five (5) years has not elapsed since the person was fully discharged from imprisonment, probation, or parole.

(b) If a certificate is granted after the two (2) year period specified in paragraph (a) of this subsection, the provider shall serve a two (2) year probationary period during which the home shall be inspected at least a quarterly basis.

Section 6[5]. Intermediate Sanctions. (1) If the cabinet determines that a certified family child-care home provider is in violation of this administrative regulation, the cabinet may, based on the severity of the violation:
(a) Require the provider to participate in additional training;
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(b) Increase the frequency of monitoring by cabinet staff;
(c) Enter into an agreement with the provider detailing the requirements for remedying a violation and achieving compliance; or
(d) Notify or require the provider to notify a parent of a child who may be affected by the situation for which an intermediate sanction has been imposed.

(2) An intermediate sanction shall result in a suspension or revocation of certification if a certified family child-care home provider:
(a) Fails to meet a condition of the intermediate sanction; or
(b) Violates a requirement of an intermediate sanction.

Section 7(6), Suspension. The cabinet shall take emergency action in accordance with KRS 13B.125, by issuing an emergency order that results in suspension of the operation of a certified family child-care home. (1) An emergency order shall:
(a) Be served to a certified family child-care home provider in accordance with KRS 13B.050(2); and
(b) Specify the regulatory violation that caused the emergency condition to exist.

(2) Upon receipt of an emergency order, the provider shall surrender the certificate of operation to the cabinet.

(3) The cabinet or its designee and the provider shall make reasonable efforts to:
(a) Notify a parent of each child in care of the suspended provider and
(b) Refer a parent for assistance in locating alternate child care arrangements.

(4) A provider’s certification for operation of a family child-care home shall be revoked if:
(a) The provider does not request a hearing; or
(b) The condition that resulted in the emergency order is not corrected within thirty (30) calendar days of service of the emergency order.

Section 8[2], Revocation.(1) A family child-care home provider’s certification shall be revoked if the provider:
(a) Knowingly misrepresents or submits false information on the application or other form required by the cabinet or its designee;
(b) Interferes with a cabinet representative’s ability to perform an official duty;
(c) Refuses, during the hours of operation, access by a parent or cabinet representative to:
1. A child; or
2. Space in the home used for child care;
(d) Is convicted of a criminal charge that threatens the health, safety, or welfare of a child in care;
(e) Is unable to operate a family child-care home due to a medical condition; or
(f) Is unable to continue to meet the requirements of KRS 199.8982(1) or Sections 2, 3, and Sections 10[9] through 19[47] of this administrative regulation.

(2) If the cabinet determines that a condition of subsection (1) of this section exists, the cabinet or its designee shall send a written notice of revocation delivered by personal service or through certified mail at least thirty (30) calendar days prior to the effective date of the revocation.

(3) The notice of revocation shall:
(a) Specify that the certification shall cease as of a specified date unless stayed pending appeal;
(b) Specify that the child care provider shall cease operation as a certified family child-care home upon revocation;
(c) Advise the family child-care home provider of the right to request an appeal on an OIG-DRCC-05, Certified Family Child-Care Home Request for Appeal[OIG-DRCC-7, Request for Appeal], prior to the effective date of the revocation;
(d) Specify that revocation shall be stayed if an appeal is requested; and
(e) Require the family child-care home provider to surrender the certificate of operation to cabinet staff when the revocation becomes effective.

(4) If a provider’s certification has been revoked, the cabinet or its designee and the provider shall make reasonable efforts to:
(a) Notify a parent of each child in care; and
(b) Refer the parent for assistance in locating alternate child care arrangements.

Section 9[9], Appeal of Denials, Intermediate Sanctions, Suspension, and Revocation. (1) If the cabinet denies certification, imposes an intermediate sanction, suspends certification, or revokes certification, the family child-care home provider may request an appeal by completing an OIG-DRCC-05 within twenty (20) calendar days of receipt of the notice of adverse action[OIG-DRCC-2].

(2) Upon request of the appeal, the provider shall be afforded a hearing in accordance with KRS Chapter 13B.

(3) [If a hearing officer’s] final order from an administrative hearing does not uphold a suspension, the provider may resume providing child care.

Section 10[9], Standards for the Provider. (1) A certified family child-care home provider shall complete annually at least nine (9) hours of cabinet-approved early care and education provider development training beginning with the second year of operation, including one and one-half (1 1/2) hours of cabinet-approved pediatric abusive head trauma training in accordance with KRS 199.8982(2):
1. Within the second year of employment or operation in child care; and
2. Every subsequent five (5) years of employment or operation in child care.

(b) A provider or assistant’s compliance with the training in accordance with paragraph (a) of this subsection or subsection (9) of this section may be verified through the cabinet-designated database maintained pursuant to 922 KAR 2:240.

(2) A provider shall not provide care for more unrelated children than the number authorized on the certificate of operation.

(3) If the provider cares for more than four (4) infants, including the provider’s own or related infants, the provider shall have an assistant present.

(4) A provider shall not care for more than six (6) children under the age of six (6) years old, including the provider’s own or related children.

(5) The maximum number of unrelated children in the care of a certified family child-care home provider shall not exceed six (6) at any one (1) time. A provider may care for four (4) related children in addition to six (6) unrelated children for a maximum child care capacity of ten (10) at any one (1) time.

(6) If a provider operates the in-home child care business for twenty-four (24) consecutive hours, the provider shall:
(a) Receive an eight (8) hour period of respite after working sixteen (16) consecutive hours; and
(b) Employ an assistant during the period of respite.

(7) Prior to being left alone with a child, an assistant shall be certified by a cabinet-approved agency in infant and child:
(a) CPR; and
(b) First aid.

(8) An assistant shall be:
(a) Eighteen (18) years of age or older;
(b) Under direct supervision of a provider;
(c) Used for providing care in a certified family child-care home; and
(d) Used in the absence of the certified provider.

(9) An assistant used in the absence of the family child-care home provider in excess of fourteen (14) calendar days during a one (1) year period shall demonstrate completion of at least nine (9) hours of cabinet-approved training, including pediatric abusive head trauma training pursuant to KRS 199.8982(2), in accordance with subsection (1) of this section.

(10) If a provider, an assistant, or a member in a provider’s household is named as the alleged perpetrator in a child abuse or neglect report accepted by the cabinet in accordance with KAR 1:320, the individual shall be removed from direct contact with a child in care:
(a) For the duration of the family-in-need-of-services assessment or investigation; and
(b) Pending completion of an administrative appeal process for a substantiation of child abuse or neglect in accordance with 922 KAR 1:320 or 922 KAR 1:480.
During hours of operation, a provider and another person in the home shall:
(a) Be free of the influence of alcohol or a controlled substance except for use of a controlled substance as prescribed by a physician; and
(b) Prohibit smoking in the presence of children in care.

During a provider's absence, an assistant shall be physically present at the home during hours of operation.

A provider shall:
(a) Not be employed outside of the home during regular hours of operation; and
(b) Maintain daily attendance records documenting the arrival and departure time of each child, including records that are required in accordance with 922 KAR 2:160, Section 13, if a child receives services from the provider through the Child Care Assistance Program;
(a) Basic health, safety, and sanitation;
(b) Recognizing and reporting child abuse;
(c) Developmentally appropriate child care practices; and
(d) Early care and education.

Section 11[44]. The General Requirements of the Family Child-Care Home Environment. (1) A provider's home and each play area used for child care shall:
(a) Be free from risk of harm in accordance with the requirements of this administrative regulation; and
(b) Have adequate:
1. Heating and cooling;
2. Light; and
3. Ventilation.

(2) Each floor level used for child care shall have at least one
(1):
(a) Unblocked exit to the outside;
(b) Smoke detector;
(c) Fire extinguisher; and
(d) Carbon monoxide detector if the home:
1. Uses fuel burning appliances; or
2. Has an attached garage.

(3) A new applicant or a provider who changes location shall have at least two (2) unblocked exits to the outside on each floor level used for child care.

(4) The areas of the home that are accessible to children in care shall be free from items harmful to children including the following items:
(a) Cleaning supplies, poisons, paints, and insecticides;
(b) Knives, scissors, and sharp objects;
(c) Power tools, lawn mowers, hand tools, nails, and other equipment;
(d) Matches, cigarettes, lighters, combustibles, and flammable liquids;
(e) Alcoholic beverages;
(f) Plastic bags; and
(g) Litter and rubbish.

(5) In accordance with KRS 527.070(1), firearms[Gun] and ammunition shall be stored away from the presence of children in separate locked containers, which, in order to be opened, require a:
(a) Key; or
(b) Combination.

(6) Electrical outlets not in use shall be covered.

(7) An electric fan, floor furnace, or freestanding heater or fireplace shall:
(a) Be out of the reach of a child; or
(b) Have a safety guard to protect a child from injury.

(8) A certified family child-care[Home] home shall have:
(a) At least one (1) working land-line telephone on each level used for child care[,] unless the cabinet has been notified that the telephone is temporarily out of service[telephone on each level used for child care with a residential or commercial line]; and
(b) A list of emergency numbers posted by each telephone, including numbers for the:
1. Police;
2. Fire station;
3. Emergency medical care and rescue squad; and
4. Poison control center.

(9) Equipment and toys shall be:
(a) Designated by the manufacturer as developmentally appropriate to the age of children in care;
(b) In sufficient quantity for the number of children in care; and
(c) Safe, sound, clean, and in good repair.

(10) [Television or video viewing by a child shall be limited to:
(a) Two (2) hours daily;
(b) The planned program activities; and
(c) Developmentally appropriate child-related content, as designated by standardized content guidelines.

(11) Stairs and steps used for children in care shall be:
(a) Solid;
(b) Safe; and
(c) Railed.

If an infant or toddler is in the care of a provider, indoor stairs with more than two (2) steps shall be blocked.

Exclusive of the bathroom and storage area, an indoor area, including furnishings, used for child care shall contain at least thirty-five (35) square feet per child for:
(a) Play; and
(b) Activities that meet the developmental needs of the children in care.

An outdoor play area shall be free of unavoidable danger or risk.

Each child in an outdoor play area shall be under the direct supervision of the provider or assistant.

Outdoor stationary play equipment shall be:
(a) Secured appropriately;
(b) Developmentally appropriate; and
(c) Age appropriate and safe.

A trampoline shall not be accessible to a child in the care of a provider.

A swimming pool on the premises shall:
(a) Be maintained;
(b) Have a water filtering system;
(c) Be supervised when in use; and
(d) Be inaccessible to children when not in use.

An above-ground pool shall have:
(a) A stationary wall no less than four (4) feet tall; and
(b) Hand holds or foot holds that are inaccessible when the pool is not in use.

A fire[and Tom] drone shall be:
(a) Conducted during hours of operation[least monthly]; and
(b) Documented.

An earthquake drill and a tornado drill shall be:
(a) Conducted during hours of operation[least quarterly]; and
(b) Documented.

A family child-care[Home] during hours of operation, the provider and other persons in the home shall:
(a) Be free of the influence of alcohol or a controlled substance, except for use of a controlled substance prescribed by a physician; and
(b) Prohibit smoking in the presence of children in care.

During a provider's absence, an assistant shall be physically present at the home during hours of operation.

A provider shall not be employed outside of the home during regular hours of operation.

The home shall:
(a) Be clean;
(b) Be uncluttered;
(c) Be free of insects and rodents;
(d) Have a water supply that is:
1. Potable;
2. Adequate; and
3. From an approved public water supply; and
(e) Have bathrooms, including toilets, sinks, and potty chairs that are:
1. Sanitary; and
2. In good working condition.

A child shall wash hands with liquid soap and warm...
running water:
(a) Before and after eating or handling food;
(b) After toileting or diaper change;
(c) After handling animals;
(d) After wiping or blowing nose;
(e) After touching items soiled with body fluids or waste; and
(f) After outdoor and indoor play time.
(27) The provider and an assistant shall:
(a) Wash hands with liquid soap and warm running water:
1. Before and after diapering a child;
2. Before and after feeding a child;
3. After toileting or assisting a child with toileting;
4. After handling animals;
5. Before dispensing medication;
6. After caring for a sick child; and
7. After wiping or blowing a child’s or own nose.
(b) Assure that a child shall not share:
1. Cups;
2. Eating utensils;
3. Wash cloths;
4. Towels; and
5. Toilet try items.
(28) The refrigerator shall:
(a) Be in working order; and
(b) Maintain product temperature at or below forty-five (45) degrees Fahrenheit.
(29) Except if thawed for preparation or use, frozen food shall be kept at a temperature of zero degrees Fahrenheit as verified by a thermometer in the freezer.
(30) While bottle feeding an infant, the:
(a) Child shall be held; and
(b) Bottle shall not be:
1. Dropped;
2. Left in the mouth of a sleeping infant; or
3. Heated in a microwave.
(31) Windows, doors, and outer openings shall be screened to prevent the entrance of vermin.
(32) Indoor and outdoor garbage shall be stored in a waterproof container with a tight-lid covering.
(33) Playpens and play yards shall:
(a) Meet the federal standards as issued by the Consumer Product Safety Commission, including 16 C.F.R. 1211;
(b) Be manufactured for commercial use; and
(c) Not be used for sleeping or napping.
(34) A provider and an assistant shall:
(a) Be able to provide basic first aid;
(b) Maintain a current immunization certificate for each child within thirty (30) days of enrollment, unless an attending physician or parent objects to the immunization of a child pursuant to KRS 214.038.
(c) Written record:
1. Completed and signed by the child’s parent;
2. Retained on file for the first day the child attends, to include:
   a. The child’s name, address, and date of birth;
   b. The name of each individual to whom the child may be released;
c. The general status of the child’s health;
(d) Developmentally appropriate child care program that assures affirmative steps are taken to protect children from abuse or neglect pursuant to KRS 600.020(1); and
(e) Maintain daily attendance records documenting the arrival and departure time of each child.
Section 12(14). Care Requirements for a Provider. (1) A provider shall ensure the health, safety, and comfort of each child.

(a) Care for a child with a special need shall be consistent with the nature of the need as documented by the child’s health professional.
(b) A child may include a person eighteen (18) years of age if the person has a special need for which child care is required.
(3) Television or video viewing by a child shall be limited to:
(a) Two (2) hours daily;
(b) The planned program activities; and
(c) Developmentally appropriate child-related content, as designated by standardized content guidelines.
(4) A child shall wash hands with liquid soap and warm running water:
(a) Before and after eating or handling food;
(b) After toileting or diaper change;
(c) After handling animals;
(d) After wiping or blowing nose;
(e) After touching items soiled with body fluids or waste; and
(f) After outdoor and indoor play time.
(5) A provider and an assistant shall:
(a) Wash hands with liquid soap and warm running water:
1. Before and after diapering a child;
2. Before and after feeding a child;
3. After toileting or assisting a child with toileting;
4. After handling animals;
5. Before dispensing medication;
6. After caring for a sick child; and
7. After wiping or blowing a child’s or own nose; and
(b) Assure that a child does not share:
1. Cups;
2. Eating utensils;
3. Wash cloths;
4. Towels; and
5. Toiletry items.

(6) An infant shall sleep and nap on the infant’s back unless the infant’s health professional signs a waiver that states the infant requires an alternate sleeping position.

(7) Rest time shall be provided for each child who is not school-age and who is in care for more than four (4) hours.

(8) Rest time shall include adequate space specified by the child’s age as follows:

(a) For an infant:
2. A firm crib mattress in good repair with a clean tight-fitted sheet that is changed:
   a. Weekly; or
   b. Immediately if it is soiled or wet;
3. No positioning device or monitor unless the device or monitor is required by the infant’s health professional;
4. No loose bedding; and
5. No toys or other items except for the infant’s pacifier; or
(b) For a toddler or preschool-age child:
1. An individual bed, a two (2) inch thick waterproof mat, or cot in good repair; and
2. Bedding that is in good repair and is changed:
   a. Weekly; or
   b. Immediately if it is soiled or wet.

(9) Rest time shall not exceed two (2) hours for a preschool-age child unless the child is attending nontraditional hours or is sick.

(10) A child who does not sleep shall be permitted to play quietly and be visually supervised.

(11) If overnight care is provided, a provider or an assistant shall:

(a) Remain awake until every child in care is asleep; and
(b) Sleep on the same floor level of the home as an infant or toddler.

(12) A certified family child care home shall provide a daily planned program:

(a) Posted in writing in a conspicuous location;
(b) Of activities that are individualized and developmentally appropriate for each child served;
(c) That provides experience to promote the individual child’s physical, emotional, social, and intellectual growth and well-being; and
(d) That offers a variety of creative activities including:
   1. Art;
   2. Music;
   3. Dramatic play;
   4. Stories and books;
   5. Science;
   6. Block building;
   7. Tactile activity;
   8. Culture;
   9. Indoor or outdoor play in which a child makes use of both small and large muscles;
10. A balance of active and quiet play, including group and individual activity; and
11. An opportunity for a child to:
   a. Have some free choice of activities;
   b. If desired, play apart from the group at times; and
   c. Practice developmentally appropriate self-help procedures in respect to:
      (i) Clothing;
      (ii) Toiletting;
      (iii) Hand-washing; and
      (iv) Eating.

(13) Except for a school-aged child whose parent has given written permission and whose whereabouts are known, a child shall not be permitted off the premises of a family child-care home without a caregiver.

(14) Use of corporal physical discipline shall be prohibited pursuant to KRS 199.896(18).

(15) A child shall be released from a family child-care home to:

(a) The child’s custodial parent;
(b) The person designated in writing by the parent to receive the child; or
(c) In an emergency, a person designated over the telephone by the parent.

Section 13. Toilet and Diapering Requirements. (1) A toilet room shall:

(a) Have an adequate supply of toilet paper; and
(b) Be cleaned and sanitized daily.

(2) A sink shall be:

(a) Located in or immediately adjacent to toilets;
(b) Equipped with hot and cold running water that allows for hand washing;
(c) Equipped with hot water at a minimum temperature of ninety (90) degrees Fahrenheit and a maximum of 120[no more than 110] degrees Fahrenheit;
(d) Equipped with liquid soap and single use, disposable hand drying material;
(e) Equipped with an easily cleanable, covered waste receptacle; and
(f) Immediately adjacent to a changing area used for infants and toddlers.

(3) Each toilet shall:

(a) Be kept in clean condition;
(b) Be kept in good repair;
(c) Be in a lighted room; and
(d) Have ventilation.

(4) Toilet training shall be coordinated with the child’s parent.

(5) An adequate quantity of freshly laundered or disposable diapers and clean clothing shall be available.

(6) If a toilet training chair is used, the chair shall be:

(a) Emptied promptly; and
(b) Sanitized after each use.

(7) Diapers or clothing shall be:

(a) Changed when soiled or wet;
(b) Stored in a covered leak proof container temporarily; and
(c) Washed or disposed of at least once a day.

(8) The proper methods of diapering and hand washing shall be posted at each diaper changing area.

(9) If a child is being diapered, the child shall:

(a) Not be left unattended; and
(b) Be placed on a surface that is:
   1. Clean;
   2. Padded;
   3. Free of holes, rips, tears, or other damage;
   4. Nonabsorbent;
   5. Easily cleaned; and
   6. Free of items not used for diaper changing.

(10) Unless prescribed by a physician, individual disposable washcloths shall be used to thoroughly clean the affected area of the child.

(11) A provider or an assistant[Staff] shall disinfect the diapering surface after each child is diapered.

(12) If a provider or an assistant[Staff] wear disposable gloves, the gloves shall be changed and disposed of after each child is diapered.

Section 14.42. Food Requirements. (1) The provider and an assistant shall:

(a) Use sanitary procedures when preparing and serving food;
(b) Refrigerate perishable food and beverages; and
(c) Serve:
   1. Breast milk or iron-fortified formula to a child age birth to twelve (12) months;
   2. Pasteurized whole milk to a child age twelve (12) months to twenty-four (24) months; or
   3. Pasteurized skim or low fat one (1) percent milk to a child age twenty-four (24) months to school-age milk or milk products that are pasteurized.

(2) Water shall be:

(a) Available to a child in care; and
(b) Served in addition to meal requirements if a child requests throughout the day.

(3) A certified family child-care home shall offer each child the same food items unless the child’s parent or health professional documents a dietary restriction that necessitates an alternative food item for the child.

(4) Second servings shall be available to a child.

(5) Food shall not be:

(a) Used for:
1. Reward;
or
2. Punishment;
or
(b) Withheld until all other food items are consumed.

(6) Meals shall:
(a) Be served in an amount appropriate to the age of the child;
and
(b) Include appropriate types of food according to the age of the child;
and
(c) Not be served during television or video viewing.

(7)(a) Breakfast shall include:
(a) Milk;
(b) Whole grain or enriched bread; and
(c) Fruit, vegetable, or 100 percent juice.

(b)(a) A snack shall include two (2) of the following:
(a) Milk;
(b) Protein source;
(c) Fruit, vegetable, or 100 percent juice; or
(d) Whole grain or enriched bread.

(b)(a) Lunch and dinner shall include:
(a) Milk;
(b) Protein source;
(c) 1. Two (2) vegetables;
2. Two (2) fruits; or
3. One (1) fruit and one (1) vegetable; and
(d) Whole grain or enriched bread.

(b)(a) A weekly menu shall be:
(a) Prepared;
(b) Dated;
(c) Posted in a conspicuous place; and
(d) Kept on file for thirty (30) calendar days.

(b)(a) Substitutions to a posted weekly menu shall be noted on the day the meal is served.

(b)(a) Unless provided as part of the fee for child care or the provider is a participant in the food program, an infant’s formula shall be prepared, labeled, and provided by the parent.

(b) Labeled; and

(c) Provided by the parent.

(b)(a) Each child’s bottle shall be:
(a) Labeled;
(b) Covered; and
(c) Refrigerated.

(b) The refrigerator shall:
(a) Be in working order; and
(b) Maintain a product temperature at or below forty (40) degrees Fahrenheit as verified by a thermometer in the freezer.

(b) While bottle-feeding an infant, the:
(a) Child shall be held; and
(b) Bottle shall not be:
1. Propped;
2. Left in the mouth of a sleeping infant; or
3. Heated in a microwave.

Section 15(13). Medication and First Aid. (1) Medication, including medicine that requires refrigeration, shall be stored in a locked container or area with a lock.

(2) Prescription and nonprescription medication shall [no] be administered to a child in care with the written daily request of the child’s parent.

(3) Prescription and nonprescription medication:
(a) May be given to a child only with the written daily request of the provider and an assistant shall:
1. Parent; or
2. Person exercising custodial control of the child; and
(b) Shall be administered according to the instructions on the label.

(4) Medications shall be:
(a) Labeled; and
(b) Administered according to directions or instructions on the label.

(5) A provider shall:
(a) Maintain first aid supplies that are easily accessible for use in an emergency, and these supplies shall be inaccessible to the children in care; and
(b) Wash superficial wounds with soap and water before bandaging.

(5)(a) First aid supplies shall include a fully-equipped first aid kit containing the following nonexpired items:
(a) Liquid soap;
(b) Adhesive bandages;
(c) Sterile gauze;
(d) Medical tape;
(e) Scissors;
(f) Thermometer;
(g) Flashlight;
(h) Cold pack;
(i) First-aid book;
(j) Disposable gloves; and
(k) CPR mouthpiece.

(6) A provider shall provide immediate notification of a medical emergency to a child’s:
(a) Parent; or
(b) Family physician, if the parent is unavailable.

(7) A quiet, separate area that is easily supervised shall be provided for a child too sick to remain with other children.

(8) A provider and an assistant shall:
(a) Be able to provide basic first aid; and
(b) Maintain a child care program that assures affirmative steps are taken to protect children from abuse or neglect pursuant to KRS 600.020(1).

Section 16(14). Animals. (1) An animal shall not be allowed in the presence of a child in care:

(a) Unless:
1. The animal is under the supervision and control of an adult;
2. Written parental consent has been obtained; and
3. The animal is certified as vaccinated against rabies; or

(b) Except in accordance with subsection (3) of this section.

Animals shall be:

(a) Supervised by an adult in the presence of children in care; and
(b) Certified as properly vaccinated against rabies;

(2) A parent shall be notified in writing if a child has been bitten or scratched by an animal.

(3) An animal that is considered undomesticated, wild, or exotic shall not be allowed at a certified family child-care home unless the animal is:

(a) A part of a planned program activity led by an animal specialist affiliated with a zoo or nature conservatory;

(b) In accordance with KRS 301 KAR 2:081 and 301 KAR 2:082.

(4) Animals that are considered undomesticated, wild, or exotic shall not be allowed in a family child care home.

Section 17(15). Transportation. (1) If transportation is provided or arranged by the certified family child-care home provider, the provider shall:

(a) Have written permission from a parent to transport his or her child;

(b) Have a car or van equipped with seat belts;

(c) Require that a child:
1. Be restrained in an appropriate safety seat meeting federal motor vehicle safety standards in accordance with KRS 189.125 and 49 C.F.R. 571.213; and
2. Remain seated while the vehicle is in motion; and
3. If under thirteen (13) years of age, be transported in the back seat;
4. Firearms, ammunition, alcohol, or illegal substances shall not be transported in a vehicle transporting children.

Section 18[46]. Records. (1) A provider shall maintain:
(a) A current immunization certificate for each child in care within thirty (30) days of the child’s enrollment, unless an attending physician or the child’s parent objects to the immunization of the child;
(b) A written record for each child:
1. Completed and signed by the child’s parent;
2. Retained on file on the first day the child attends the family child-care home; and
(c) The name and phone number of each person to be contacted in an emergency situation involving or impacting the child;
(d) Authorization by the parent for the provider to seek emergency medical care for the child in the parent’s absence; and
(e) A permission form for each trip away from the family child-care home signed by the child’s parent in accordance with Section 17(1) of this administrative regulation; and
(f) Daily attendance records documenting the arrival and departure time of each child, including records that are required in accordance with 922 KAR 2:160, Section 13, if a child receives services from the provider through the Child Care Assistance Program.
(2) A certified family child-care home provider shall maintain the confidentiality of a child’s records.
(3)(a) The cabinet shall provide, upon request, public information pursuant to KRS 199.8982(1)(a)(1)(a); and
(b) A certified family child-care home provider shall have a written evacuation plan in the event of fire, natural disaster, or other threatening situation that may pose a health or safety hazard to a child in care in accordance with KRS 199.895.
(c) The cabinet shall post an online template of an evacuation plan that:
1. Fulfills requirements of KRS 199.895;
2. Is optional for an applicant or a family child-care home’s use(completion); and
3. Is available to an applicant or a family child-care home without charge.

Section 19[47]. Certified Family Child-Care Home Program. The certified family child-care home provider shall:
1. Develop written information that specifies the:
(a) Rate for child care;
(b) Expected frequency of payment for the program;
(c) Hours of operation; and
(d) Policy regarding:
1. Late fees;
2. Holidays;
3. Vacation;
4. Illness; and
5. Emergency pick up;
2. Make available a copy of the certification standards to each parent;
3. Provide each parent with the name, address, and telephone number of the cabinet for the purpose of registering a complaint if the parent believes the family child-care home provider is not meeting the standards;
4. Post and provide to each parent a copy of children and parent rights, as required by KRS 199.898;
5. Allow a parent and the cabinet or its designee access to the family child-care home at any time a child is in care;
6. Communicate with each child’s parent about the child’s:
(a) Development;
(b) Activities;
(c) Likes; and
(d) Dislikes;
7. Post in a prominent area in the home:
(a) A current immunization certificate;
(b) The planned program of activities;
(c) Likes; and
(d) Dislikes;
8. Coordinate at least one (1) annual activity involving parental or family participation.[and]
9. Maintain a written child care agreement with each child’s parent, including the name of each person designated by the parent to pick up the child; and
10. Report:
(a) The following to the cabinet within twenty-four (24) hours from the time of discovery:
1. A communicable disease, which shall also be reported to the local health department pursuant to KRS 214.060;
2. An accident or injury to a child that requires medical care;
3. An incident that results in legal action by or against the family child-care home that affects:
(a) A child in care;
(b) The provider;
(c) An assistant; or
(d) A member of the provider’s household;
4. An incident involving fire or other emergency; or
5. A report of child abuse or neglect that:
(a) Has been accepted by the cabinet in accordance with 922 KAR 1:330; and
(b) Names the alleged perpetrator as the:
(i) Provider;
(ii) Provider’s assistant; or
(ii) Member of the provider’s household;
(b) The death of a child to the cabinet within one (1) hour; or
(c) Temporary or permanent closure as soon as practicable to the cabinet and the parent of a child in the family child-care home.

Section 20(4). Incorporation by Reference. (1) The following material is incorporated by reference:
(a) “OIG-DRCC-03, Certification Application for Family Child-Care Home”, edition 8/3/12;
(b) “OIG-DRCC-04, Certified Family Child-Care Home Central Registry Check”, edition 8/6/12(2/13/12);
(c) “OIG-DRCC-05, Certified Family Child-Care Home Request for Appeal” edition 8/3/12(OIG-CC-3, Application for Certified Family Child Care Home”, edition 12/07;
(b) “OIG-CC-5, Central Registry Check”, edition 12/07;
(c) “OIG-CC-6, Self Check List”, edition 12/07; and

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Community-Based Services, Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

TERESA C. JAMES, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: September 13, 2012
FILED WITH LRC: September 13, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

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CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Child Care
(As Amended at ARRS, January 7, 2013)

922 KAR 2:110. Child-care center provider requirements.


STATUTORY AUTHORITY: KRS 194A.050(1), 199.896(2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the Secretary of the Cabinet for Health and Family Services to promulgate administrative regulations necessary to operate programs and fulfill responsibilities vested in the cabinet, qualify for the receipt of federal funds, and cooperate with other state and federal agencies for the proper administration of the cabinet and its programs. KRS 199.896(2) authorizes the Cabinet for Health and Family Services to promulgate administrative regulations and standards for child-care centers. This administrative regulation establishes standards for child-care centers.

Section 1. Definitions. (1) “Address check” means a cabinet search of the Sex Offender Registry to determine if a person’s residence is a known address of a registered sex offender.
(2) “Cabinet” is defined by KRS 199.011(2).
(3)[(4)] “Child care” means care of a child in a center or home which regularly provides full or part-time care, day or night, and includes developmentally appropriate[developmentally appropriate] play and learning activities.
(4)[(3)] “Child-care center” is defined by KRS 199.894(3).
(5)[(4)] “Director” means an individual who meets the education and training requirements as specified in Section 4 of this administrative regulation.
(6)[(5)] “Health professional” means a person actively licensed as a:
(a) Physician;
(b) Physician’s assistant;
(c) Advanced registered nurse practitioner; or
(d) Registered nurse as defined by KRS 314.011(5) under the supervision of a physician.

[7] Infant” means a child who is less than twelve (12) months of age.
[8][4] “Licensee” means the owner and operator of a child-care center to include:
(a) Sole proprietor;
(b) Corporation;
(c) Limited liability company;
(d) Partnership;
(e) Association;
(f) Organization, such as:
1. Board of education;
2. Private school;
3. Faith based organization;
4. Government agency; or
5. Institution[an individual, partnership, corporation, or other entity authorized to operate a child-care center].
[9][4] “Parent” is defined by 45 C.F.R. 98.2.
[10][4] “Parental or family participation” means a child-care center agreement provision for information or formal inclusion of a child’s parent in the child-care center’s activities such as:
(a) Distribution of a newsletter;
(b) Distribution of a program calendar;
(c) A conference between the provider and a parent; or
(d) Other activity designed to engage a parent in the program’s activities.
[11] “Pediatric abusive head trauma” means the building and contiguous property in which child care is provided.
[12][4] “Preschool-age” means a child who is older than a toddler and younger than school-age.
[13][4] “Qualified substitute” means a person who meets the requirements of a staff person as described in Section 5 of this administrative regulation.
[14][4] “School-age” means a child attending kindergarten, elementary, or secondary education.
[15][4] “Sex Offender Registry” means the registration system for adults who have committed sex crimes or crimes against minors established in accordance with KRS 17.500 through 17.580.
[16][4] “Toddler” means a child between the age of twelve months and twenty-four (24) months.
[17][4] “Type I child-care center” means a child-care center licensed to regularly provide child care services for:
(a) Four (4) or more children in a nonresidential setting; or
(b) Thirteen (13) or more children in a residential setting with designated space separate from the primary residence of a licensee.
[18][4] “Type II child-care center” means the primary residence of the licensee in which child care is regularly provided for at least seven (7), but not more than twelve (12), children including children related to the licensee.

Section 2. General. (1) A licensee shall be responsible for the operation of the child-care center pursuant to this administrative regulation, 922 KAR 2:090, and 922 KAR 2:120.
(2) Child-care center staff shall be:
(a) Instructed by the child-care center’s director regarding requirements for operation; and
(b) Provided with a copy of this administrative regulation, 922 KAR 2:090, and 922 KAR 2:120.
(3) Information concerning a child or the child’s parent shall be kept in strict confidence by child-care center staff, except as otherwise required by law.
(4) A volunteer or board member shall comply with the policies and procedures of the child-care center.
(5) Program policies and procedures shall:
(a) Be in writing; and
(b) Include:
1. Staff policies;
2. Job descriptions;
3. An organization chart;
4. Chain of command; and
5. Other procedures necessary to ensure implementation of:
   a. KRS 199.898, Rights for children in child-care programs and...
their parents, custodians, or guardians - posting and distribution requirements;

b. 922 KAR 2:090, Child-care center licensure;
c. 922 KAR 2:120, Child-care center health and safety standards; and
d. This administrative regulation.

(6) An activity of a person living in a child-care center that is a dwelling unit shall not interfere with the child-care center program.

(7) In addition to the posting requirement of KRS 199.898(3), a child-care center shall post the following in a conspicuous place and make available for public inspection:

(a) Each statement of deficiency and civil [monetary] penalty notice issued by the cabinet during the current licensure year;
(b) Each plan of correction submitted by the child-care center to the cabinet during the current licensure year;
(c) Information on the Kentucky Consumer Product Safety Program and the program's Web site as specified in KRS 199.897;
(d) A description of services provided by the child-care center, including:
   1. Current rates for child care; and
   2. Each service charged separately and in addition to the basic rate for child care;[4]
   
[(e)(e)] Minimum staff-to-child ratios and group size established in 922 KAR 2:120; and

[(f)(a)] Daily schedule.

(b) A director, employee, volunteer, or any person with supervisory or disciplinary control over, or having unsupervised contact with a child in care is named as the alleged perpetrator in a child abuse or neglect report accepted by the cabinet in accordance with 922 KAR 1:330, the individual shall be removed from direct contact with a child in care:

(a) For the duration of the family-in-need-of-services assessment, investigation, and

(b) Pending completion of the administrative appeal process for a cabinet substantiation of child abuse or neglect in accordance with 922 KAR 2:120 and

(c) For a cabinet substantiation of child abuse or neglect in accordance with 922 KAR 1:320 or 922 KAR 1:480.

Section 3. Records. (1) A child-care center shall maintain:

(a) A current immunization certificate for each child in care within thirty (30) days of the child’s enrollment, unless an attending physician or the child’s parent objects to the immunization of the child pursuant to KRS 214.036;

(b) A written record for each child:
   1. Completed and signed by the child’s parent;
   2. Retained on file on the first day the child attends the child-care center; and
   3. To contain:
   a. Identifying information about the child, which includes, at a minimum, the child’s name, address, and date of birth;
   b. Contact information to enable a person in charge to contact the child’s:
      i) Parent at the parent’s home or place of employment;
      ii) Family physician; and
      iii) Preferred hospital;
   c. The name of each person who is designated in writing to pick-up the child;
   d. The child’s general health status and medical history including, if applicable:
      i) Allergies;
      ii) Restriction on the child’s participation in activities with specific instructions from the child’s parent or health professional; and
      iii) Permission from the parent for third-party professional services in the child-care center;
   e. The name and phone number of each person to be contacted in an emergency situation involving or impacting the child;
   f. Authorization by the parent for the child-care center to seek emergency medical care for the child in the parent’s absence; and
   g. A permission form for each trip off the premises signed by the child’s parent in accordance with 922 KAR 2:120. Section 12;

(c) Daily attendance records documenting the arrival and departure time of each child, including records that are required in accordance with 922 KAR 2:160, Section 13, if a child receives services from the child-care center through the Child Care Assistance Program;

(d) A written schedule of staff working hours;

(e) A current personnel file for each child-care center staff person to include:
   1. Name, address, date of birth, and date of employment;
   2. Proof of educational qualifications;
   3. Record of annual performance evaluation;
   4. Written record of training participation to include:
      a. The training source;
      b. Location;
      c. Date; and
   d. Number of clock hours completed;
   5. Every two (2) years:
      a. Statement from a health professional that the individual is free of active tuberculosis; or
      b. Copy of negative tuberculin results; and
   6. For a director, employee, volunteer, or any person with supervisory or disciplinary control over, or having unsupervised contact with, a child in care, the results of a:
      a. Child abuse or neglect check using the central registry in accordance with 922 KAR 1:470;
      b. Criminal records check required by KRS 199.896(19);
      c. Criminal records check from any previous state of residence completed once if:
         i) The individual resided outside the state of Kentucky in the last five (5) years; and
   d. No criminal records check has been completed for the individual’s previous state of residence; and
   d. An address check of the Sex Offender Registry;
   i) A written annual plan for child-care staff professional development;
   g. A written evacuation plan in accordance with 922 KAR 2:090. Section 5, and KRS 199.895;
   h. A written record of the rescue practiced earthquake drills and tornado drills detailing the date, time, and children who participated in accordance with 922 KAR 2:120. Section 3;
   (i) A written record of practiced fire drills conducted monthly detailing the date, time, and children who participated in accordance with 922 KAR 2:120, Section 3;
   (j) A written plan and diagram outlining the course of action in the event of a natural or manmade disaster, posted in a prominent place;
   k) A written record of reports to the cabinet required in Section 6 of this administrative regulation; and
   l) A written record of transportation services provided in accordance with 922 KAR 2:120, Section 12;

(2) A child-care center shall:

(a) Maintain the confidentiality of a child’s record;
(b) Maintain all records for five (5) years; and
(c) Provide the cabinet access and information in the completion of the investigation pursuant to KRS 620.030(4). The following records shall be maintained at the child-care center for five (5) years:

1) Sufficient records to:
   a. Identify each child enrolled in the child-care center; and
   b. Enable the person in charge to contact each child’s:
      1. Parent at:
         a. Home; or
         b. Place of employment; and
      2. Family physician; and
         a. Identify the name of each person designated in writing by the parent to pick-up the child;
         b. Each child’s medical history, along with authorization for emergency medical care, signed by the parent and left with the child-care center director at the time of enrollment;
   (2) Except as provided in KRS 214.036, a current immunization certificate showing that the child is immunized pursuant to 902 KAR 2:060, placed on file within thirty (30) days of enrollment;
   (3) Permission forms for each trip off the premises signed by the parent;
   (4) Daily attendance records documenting the arrival and departure time of each child;
   (5) A written schedule of staff working hours;
   (6) A written record of training participation for each child-care center staff person, to include:
(a) The training source;
(b) Location;
(c) Date; and
(d) Number of clock hours completed;
(e) A written annual plan for child care staff professional development;
(f) A written record of quarterly, practiced earthquake and tornado drills detailing the date, time, and children who participated;
(g) A written plan and diagram outlining the course of action in the event of natural or manmade disaster, posted in a prominent place;
(h) A written record of reports to the cabinet required in Section 4 of this administrative regulation.

Section 4. Director Requirements and Responsibilities.

(1) Effective with the adoption of this administrative regulation, a director shall:
(a) Be twenty-one (21) years of age;
(b) Have a high school diploma, a general equivalency diploma (GED), or qualifying documentation from a comparable educational entity;
(c) Not be employed in a position other than an on-site child care director, or director of multiple facilities, during the hours the child-care center is in operation; and
(d) Ensure:
1. Compliance with 922 KAR 2:090, 922 KAR 2:120, and this administrative regulation; and
2. The designation of one (1) adult staff person in charge to carry out the director’s duties if the director is not present in the child-care center during operating hours;
(e) Develop child-care center plans, policies, and procedures;
(f) Supervise staff conduct to ensure implementation of program policies and procedures;
(g) Post a schedule of daily activities, to include dates, times, and locations, of activities to be conducted with the children in each classroom;
(i) Conduct, manage, and document in writing staff meetings;
(j) Assess each staff person’s interaction with children in care and classroom performance through an annual written performance evaluation;
(k) Ensure that additional staff are available during cooking and cleaning hours, if necessary, to maintain staff-to-child ratios pursuant to 922 KAR 2:120;
(l) Provide for the health, safety, and comfort of each child;
(m) Notify the parent immediately of an accident or incident requiring medical treatment of a child;
(n) Assure that a person acting as a caregiver of a child in care shall not be left alone with a child, if the licensees has not received the results of the background checks as described in Section 3(1)(e)6 of this administrative regulation.

1. Criminal records check required by KRS 199.896(19); and
2. Child abuse and neglect check in accordance with 922 KAR 1:470;

(o) Assure that mandatory record specified in Section 3 of this administrative regulation has not been altered or falsified; and
(p) Coordinate at least one (1) annual activity involving parental or family participation.

(2) The director of a Type I child-care center shall meet one (1) of the following educational requirements:
(a) Master’s degree in Early Childhood Education and Development;
(b) Bachelor’s degree in Early Childhood Education and Development;
(c) Master’s degree or a bachelor’s degree in a field other than Early Childhood Education and Development, including a degree in pastoral care and counseling, plus twelve (12) clock hours of child development training;
(d) Associate degree in Early Childhood Education and Development;
(e) Associate degree in a field other than Early Childhood Education and Development, plus twelve (12) clock hours of child development training, and two (2) years of verifiable full-time paid experience working directly with children in
(f) A Director’s Credential in Early Childhood Development and one (1) year of verifiable full-time paid experience working directly with children in:
1. A school-based program following Department of Education guidelines;
2. An early childhood development program, such as Head Start; or
3. A licensed or certified child care program;
(g) A Director’s Credential in Early Childhood Development and one (1) year of verifiable full-time paid experience working directly with children in:
1. A school-based program following Department of Education guidelines;
2. An early childhood development program, such as Head Start; or
3. A licensed or certified child care program;
(h) Three (3) years of verifiable full-time paid experience working directly with children in:
1. A school-based program following Department of Education guidelines;
2. An early childhood development program, such as Head Start; or
3. A licensed or certified child care program; or

Section 5. Staff Requirements.

(1) Child-care center staff:
(a) Hired after January 1, 2009, who have supervisory power over a minor and are not enrolled in secondary education, shall have a
1. High school diploma;
2. GED or qualifying documentation from a comparable educational entity;
3. Commonwealth Child Care Credential as described in 922 KAR 2:090, 922 KAR 2:120, and this administrative regulation;
4. An early childhood development program, such as Head Start; or
5. A licensed or certified child care program; or
6. Obtain six (6) additional hours of training in child day care program administration.

(b) Shall provide, prior to employment and every two (2) years thereafter:
1. A statement from a health professional that the individual is free of active tuberculosis;
2. A copy of negative tuberculin test result(s) [the results of a negative tuberculin skin test];
3. A statement from a health professional that the individual is free of active tuberculosis;

(2) A child-care center shall not employ a person:
(a) Convicted of a crime pursuant to KRS 17.165(5)(a).
(b) Found by the cabinet to have abused or neglected a child, pursuant to 922 KAR 1:470;
(c) Convicted of a drug-related felony, and five (5) years has not elapsed since the person was fully discharged from imprisonment, probation, or parole;
(d) Placed on the Sex Offender Registry; or
(e) Determined by a physician to have a health condition that renders the person unable to care for children.
(3) For a child-care center licensed for infant, toddler, or preschool-age children, at least one (1) person on duty and present with the children shall be currently certified by a cabinet-approved training agency in the following skills:
(a) Infant and child cardiopulmonary resuscitation; and
(b) Infant and child first aid.
(4) For a child-care center licensed for school-age children, at least one (1) person on duty and present with the children shall be currently certified by a cabinet-approved training agency in the following skills:
(a) Adult cardiopulmonary resuscitation; and
(b) First aid.
(5) Cardiopulmonary [infant and child cardiopulmonary] resuscitation (CPR) and first aid training shall be in addition to the fifteen (15) clock hours requirement in subsection (14) of this section.[5]

One (1) adult staff person shall be designated as being in charge.
If the director is not present in the child-care center, the designated staff person in charge shall carry out the duties of the director.

(b) Each child care centers shall have available in case of need:
(a) One (1) qualified substitute staff person for a Type II child-care center; or
(b) Two (2) qualified substitute staff persons for a Type I child-care center.
(7) Each qualified substitute staff person shall:
(a) Meet the staff requirements of this administrative regulation;
and
(b) Provide the required documentation to verify compliance with this administrative regulation.
(8) A qualified substitute who works in more than one (1) licensed child-care center shall provide the required documentation to verify compliance with this administrative regulation at the time of employment with each child-care center.
(9) If the operator of a Type II child-care center is unable to provide care in accordance with this administrative regulation, 922 KAR 2:090, or 922 KAR 2:120, the Type II child-care center shall close temporarily until the operator is able to resume compliance.[1]

10. The minimum number of adult workers in a child-care center shall be sufficient to ensure that:
(a) Minimum staff-to-child ratios in accordance with 922 KAR 2:120 are followed;
(b) Each staff person under eighteen (18) years of age and each student trainee are under the direct supervision of a qualified staff person who meets the requirements of this section; and
(c) Unless providing care with a qualified staff person, a person under the age of eighteen (18) shall not be counted as staff for the staff-to-child ratio.
(11) Except for medication as prescribed by a physician, a controlled substance or alcohol use shall not be permitted on the premises during hours of operation.
(12) Each staff person shall remain awake while on duty except as specified in 922 KAR 2:120, Section 2(11)(f).
(13)(a) For each adult residing at a Type II child-care center, the results of the following shall be maintained on file at the center:
1. (a) Criminal records check indicating that the adult has not been convicted of;
   a. Crime pursuant to KRS 17.165(55); or
   b. Drug-related felony, and five (5) years have not lapsed since the person was fully discharged from imprisonment, probation, or parole;
2. (b) Child abuse and neglect check using the central registry(sheets) in accordance with 922 KAR 1:470, indicating that the adult has not been found by the cabinet to have abused or neglected a child;
3. A criminal records check for any previous state of residence completed once if:
   a. The adult resided outside the state of Kentucky in the last five (5) years; and
   b. No criminal records check has been completed for the adult’s previous state of residence; and
4. (c) A copy of negative tuberculin results [the results of a negative tuberculin skin test] or a health professional’s statement documenting that the adult is free of tuberculosis. Every two (2) years, the adult shall provide negative tuberculin results[evidence of a negative tuberculin skin test] or health professional’s statement
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Child Care
(As Amended at ARRS, January 7, 2013)


STATUTORY AUTHORITY: KRS 194A.050(1), 199.896(2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the Secretary of the Cabinet for Health and Family Services to promulgate administrative regulations necessary to operate programs and fulfill the responsibilities vested in the cabinet, quality for the receipt of federal funds, and cooperate with other state and federal agencies for the proper administration of the cabinet and its programs. KRS 199.896(2) authorizes the Cabinet for Health and Family Services to promulgate administrative regulations and standards for child care centers. This administrative regulation establishes health and safety standards for child-care centers.

Section 1. Definitions. (1)“Adequate supervision“ means that qualified staff devotes full-time attention to a child in care and ensures the child is within scope of vision and range of voice.

(2) “Cabinet“ is defined by KRS 199.894(1).

(3) “Corporal physical discipline“ is defined by KRS 199.896(18).

(4) “Director“ means an individual:

(a) Who meets the education and training requirements as specified in 922 KAR 2:110, Section 4;

(b) Whose primary full-time job responsibilities are to ensure compliance with 922 KAR 2:090, 922 KAR 2:110, and this administrative regulation; and

(c) Who is responsible for directing the program and managing the staff at the child-care center.

(5) “Health professional“ means a person currently licensed as a:

(a) Physician;

(b) Physician’s assistant;

(c) Advanced registered nurse practitioner; or

(d) Registered nurse as defined in KRS 314.011(5) under the supervision of a physician.

(6) “Infant“ means a child who is less than twelve (12) months of age.

(7) “Licensee“ means the owner and operator of a child-care center to include:

(a) Sole proprietor;

(b) Corporation;

(c) Limited liability company;

(d) Partnership;

(e) Association; or

(f) Organization, such as:

1. Board of education;

2. Private school;

3. Faith-based organization;

4. Government agency; or

5. Institution[an individual, partnership, corporation, or other entity authorized to operate a child-care center].

(8) “Nontraditional hours“ means the hours of:

(a) 7[6] p.m. through 9[6] a.m. Monday through Friday; or

(b) 7[6] p.m. on Friday until 9[6] a.m. on Monday.

(9) “Parent“ is defined in 45 C.F.R. 98.2.

(10) “Premises“ means the building and contiguous property in which child care is provided.

(11) “Preschool-age“ means a child who is older than a toddler and younger than school-age.

(12) “Protective surface“ means loose surfacing material not installed over concrete which includes the following:

(a) Wood mulch;

(b) Double shredded bark mulch;

(c) Uniform wood chips;

(d) Fine sand;

(e) Coarse sand;

(f) Pea gravel, except for areas used by children under three (3) years of age;

(g) Certified shock absorbing resilient material; or

(h) Other material approved by the cabinet or designee.

(11) “Related“ means having one (1) of the following relationships with the operator of the child-care[child care] center:

(a) [1] Child;

(b) [2] Grandchild;

(c) [3] Niece;

(d) [4] Nephew;

(e) [5] Sibling;

(f) [6] Stepchild; or

(g) [7] Child in legal custody of the operator.

(12) “School-age“ means a child attending[enrolled in] kindergarten, elementary, or secondary education.

(13) “Stepchild“ means a child between the age of twelve (12) months and twenty-four (24) months.

(14) “Transition“ means the changing from one (1) child care arrangement to another.

(15) “Transition plan“ means a document outlining the process to be used in moving a child from one (1) child care arrangement to another.

(16) “Type I child care center“ means a child care center licensed to regularly provide child care services for:

(a) Four (4) or more children in a nonresidential setting; or

(b) Thirteen (13) or more children in a residential setting with designated space separate from the primary residence of a licensee.

(17) “Type II child care center“ means the primary residence of the licensee in which child care is regularly provided for at least seven (7), but not more than twelve (12), children including children related to the licensee.

Section 2. Child Care Services. (1) Services described in this administrative regulation shall be maintained during all hours of operation that child care is provided.

(2) Minimum staff-to-child ratios and group size for an operating child-care center shall be maintained as follows:

<table>
<thead>
<tr>
<th>Age of Children</th>
<th>Ratio</th>
<th>Maximum Group Size*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>1 staff for 5 children</td>
<td>10</td>
</tr>
<tr>
<td>Toddler</td>
<td>1 staff for 6 children</td>
<td>12</td>
</tr>
<tr>
<td>Preschool-age</td>
<td>2 to 3 years</td>
<td>1 staff for 10 children</td>
</tr>
<tr>
<td>Preschool-age</td>
<td>3 to 4 years</td>
<td>1 staff for 12 children</td>
</tr>
<tr>
<td>Preschool-age</td>
<td>4 to 5 years</td>
<td>1 staff for 14 children</td>
</tr>
<tr>
<td>School-age</td>
<td>5 to 7 years</td>
<td>1 staff for 15 children</td>
</tr>
<tr>
<td>School-age</td>
<td>7 and older</td>
<td>1 staff for 25 children (for before and after school)</td>
</tr>
</tbody>
</table>

*Maximum Group Size shall be applicable only to Type I child care centers.

(a) In a Type I child-care center, a group size shall:

1. Be separately maintained in a defined area unique to the group; and

2. Have specific staff assigned to, and responsible for, the group.

(b) The age of the youngest child in the group shall determine the:

1. Staff-to-child ratio; and
2. Maximum group size.

(c) This subsection and subsection (9) of this section shall not apply during normal school hours to a center:

1. Providing early childhood education to mixed-age groups of children whose ages range from two and one-half (2 1/2) years to six (6) years; and
2. Accredited by or affiliated with a nationally-recognized education association that has criteria for group size and staff-to-child ratios contrary to the requirements of this subsection.

(d) If a child related to the director, employee, or person under the supervision of the licensee is receiving care in the center, the child shall be included in the staff-to-child ratio.

(3)(a) Each center shall maintain a child-care program that assures each child will be:
1. Provided with adequate supervision at all times by a qualified staff person:
   a. Ensures the child is:
      1. Within scope of vision and range of voice; or
      2. For a school-age child, within scope of vision or range of voice; and
   b. Protected from abuse or neglect.
2. The program shall include:
   1. A procedure to inform child care staff of the laws of the Commonwealth pertaining to child abuse or neglect set forth in KRS 620.030; and
   2. Written policy that specifies that the procedures that were taught at the orientation training shall be implemented by each child-care center staff member.

(4) The child-care center shall provide a daily planned program of activities:

   a. (i) Of activities that are individualized and developmentally appropriate for each child served;
   b. (ii) Of activities that are developmentally appropriate for each child served;
   c. (iii) That provides experience to promote the individual child's physical, emotional, social, and intellectual growth and well-being; and
   d. (iv) That offers a variety of creative activities including the following:
      1. Art;
      2. Music;
      3. Dramatic play;
      4. Stories and books;
      5. Science;
      6. Block building;
      7. Tactile activity;
      8. Culture;
      9. Indoor or outdoor play in which a child makes use of both small and large muscles;
      10. A balance of active and quiet play, including group and individual activity;
      11. An opportunity for a child to:
         a. Have some free choice of activities;
         b. If desired, play apart from the group at times; and
         c. Practice developmentally appropriate self-help procedures in respect to:
            (i) Clothing;
            (ii) Toileting;
            (iii) Hand-washing; and
            (iv) Eating; and
         12. Use of electronic viewing and listening devices if the:
            a. Material is appropriate to the child using the equipment;
            b. Material does not include any violence, adult content viewing, or inappropriate language;
            c. Viewing or individual listening is limited to two (2) hours per day;
            d. Viewing or listening is discussed with parents prior to viewing or listening; and
            e. Viewing or listening is designed as an educational tool.
   (5) A child who does not wish to use the electronic devices during the planned program shall be offered other appropriate activities.

(6) Regularity of routines shall be implemented to afford the child familiarity with the daily schedule of activity.

(7) Sufficient time shall be allowed for an activity so that a child may progress at their own developmental rate.

(8) A child shall not be required to stand or sit for a prolonged period of time:
   a. During an activity;
   b. While waiting for an activity to start; or
   c. As punishment.

(9) If school-age care is provided:
   a. A separate area or room shall be provided in a Type I child-care center; and
   b. Each child shall be provided a snack after school.

(b) A child shall not be subjected to:
   a. Corporal physical discipline pursuant to KRS 199.896(18);
   b. Loud, profane, threatening, frightening, or abusive language; or
   c. Discipline that is associated with:
      1. Rest;
      2. Toileting; or
      3. Food.

(11) If nontraditional hours of care are provided:
   a. Including time spent in school, a child shall not be permitted to spend more than sixteen (16) hours in the child-care center during one (1) twenty-four (24) hour period;
   b. At least one (1) staff member shall be assigned responsibility for each sleeping room;
   c. A child present for an extended period of time during waking hours shall receive a program of well-balanced and constructive activity that is developmentally appropriate for the child's age and developmental needs;

(12) A child shall:
   a. Have some free choice of activities;
   b. If desired, play apart from the group at times; and
   c. Practice developmentally appropriate self-help procedures in respect to:
      1. Clothing;
      2. Toileting;
      3. Hand-washing; and
      4. Eating; and
2. After touching items soiled with body fluids or wastes; and
3. After handling animals;

(c) Discipline that is associated with:
   1. Rest;
   2. Toileting; or
   3. Food.

(11) If nontraditional hours of care are provided:
   a. Including time spent in school, a child shall not be permitted to spend more than sixteen (16) hours in the child-care center during one (1) twenty-four (24) hour period;
   b. At least one (1) staff member shall be assigned responsibility for each sleeping room;
   c. A child present for an extended period of time during waking hours shall receive a program of well-balanced and constructive activity that is developmentally appropriate for the child's age and developmental needs;

(b) A child may include a person eighteen (18) years of age if the person has a special need for which child care is required.

Section 3. General Requirements. (1) Electronic viewing and listening devices shall only be used in the center as a part of the child's program of activity described in Section 2(4) of this administrative regulation.

(2) Activity areas, equipment, and materials shall be arranged so that the child's activity can be given adequate supervision by staff.

(3) Computer equipment shall be equipped with a monitoring device which limits access by a child to items inappropriate for a child to view or hear.

(4) A child shall:
   a. Be helped with personal care and cleanliness based on their developmental skills; and
   b. Wash his or her hands with liquid soap and warm running water:
      1. Upon arrival at the center; or
      2. Within thirty (30) minutes of arrival for school-age children;
      3. Before and after eating or handling food;
      4. After toileting or diaper change;
      5. After handling animals;
      6. After touching items soiled with body fluids or wastes; and
      7. After outdoor or indoor play time.

(5) Staff shall:
   a. Maintain personal cleanliness;
   b. Conform to hygienic practices while on duty; and
   c. Wash their hands with liquid soap and running water:
1. Upon arrival at the center;
2. After toileting or assisting a child in toileting;
3. Before and after diapering each child;
4. After wiping or blowing a child’s or own nose;
5. After handling animals;
6. After caring for a sick child;
7. Before and after feeding a child or eating;
8. Before dispensing medication; and
9. If possible, before administering first aid.

6. A staff person suspected of being infected with a communicable disease shall:
   (a) Not perform duties that may allow for the transmission of the disease until the infectious condition can no longer be transmitted; and
   (b) Provide a statement from a health professional, if requested.

7. Except in accordance with subsection (8) of this section, the following shall be inaccessible to a child in care:
   (a) Toxins cleaning supplies, poisons, and insecticides;
   (b) Knives and sharp objects;
   (c) Matches, cigarettes, lighters, and flammable liquids;
   (d) Plastic bags;
   (e) Litter and rubbish;
   (f) Bar soap; and
   (g) Personal belongings and medications of staff.

8. The following shall be inaccessible to a child in care unless under direct supervision and part of planned program of instruction:
   (a) Knives and sharp objects;
   (b) Litter and rubbish; and
   (c) Plastic bags not used for personal belongings.

9. In accordance with KRS 527.070(1), firearms shall be stored separately in a locked area outside of the designated child care area.

10. Smoking shall:
    (a) Be permitted in accordance with local ordinances; and
    (b) Be allowed only in outside designated areas; and
    (c) Not be permitted in the presence of a child.

11. While bottle feeding an infant, the:
    (a) Child shall be held; and
    (b) Bottle shall not be:
        1. Propped;
        2. Left in the mouth of a sleeping infant; or
        3. Heated in a microwave.

12. A fire drill shall be:
    (a) Conducted during hours of operation;
    (b) Documented;
    (c) At least monthly; and
    (d) Conducted during hours of operation;
    (e) At least quarterly; and
    (f) Documented.

13. An earthquake drill and a tornado drill shall be:
    (a) Conducted during hours of operation;
    (b) Documented;
    (c) At least monthly; and
    (d) Conducted during hours of operation.

14. A working carbon monoxide detector shall be required in a licensed child-care center that is in a home if the home:
    (a) Uses fuel burning appliances; or
    (b) Has an attached garage.

15. The building shall be constructed to ensure the:
    (a) Building is:
        (1) Suitable for the purpose intended;
        (2) Kept clean and in good repair; and
        (3) Equipped with a working land-line telephone accessible to a room used by a child.
    (b) A child-care center shall be in compliance with the State Fire Marshal [requirements established in KRS 227.220] and the local zoning laws.
    (c) Fire and emergency exits shall be kept clear of debris.
    (d) A working carbon monoxide detector shall be required in a licensed child-care center that is in a home if the home:
        (1) Uses fuel burning appliances; or
        (2) Has an attached garage.
    (e) The building shall be constructed to ensure the:
        (1) Building is:

16. Exclusive of the kitchen, bathroom, hallway, and storage area, there shall be a minimum of thirty-five (35) square feet of space per child.

17. Measures shall be utilized to control the presence of:
    (a) Rodents;
    (b) Flies;
    (c) Roaches; and
    (d) Other vermin.

18. An opening to the outside shall be effectively protected against the entrance of vermin by:
    (a) Self-closing doors;
    (b) Closed windows;
    (c) Screening;
    (d) Controlled air current; or
    (e) Other effective means.

19. Floors, walls, and ceilings shall be smooth, in good repair, and constructed to be easily cleaned.

20. The water supply shall be:
    (a) Potable;
    (b) Protected from contamination;
    (c) Adequate in quality and volume;
    (d) Under sufficient pressure to permit unrestricted use; and
    (e) Obtained from an approved public water supply or a source approved by the local health department.

21. Groundwater supplies for a child-care center caring for:
    (a) More than twenty-five (25) children shall meet the specifications of the Cabinet for Environmental and Public Protection Division of Water, established in KRS Chapter 151; or
    (b) Twenty-five (25) children or less shall secure approval from the:
        (1) Cabinet for Environmental and Public Protection; or
        (2) Local health department.

22. Sewage shall be properly disposed by a method approved by the:
    (a) Cabinet for Environmental and Public Protection; or
    (b) Cabinet.

23. All plumbing shall comply with the State Plumbing Code established in KRS Chapter 319.

24. Solid waste shall be kept in a suitable receptacle in accordance with local, county, and state law, as governed by KRS 211.350 to 211.380.

25. If a portion of the building is used for a purpose other than child care, necessary provisions shall be made to avoid interference with the child-care program.

26. The temperature of the inside area of the premises shall be:
    (a) Sixty-five (65) to seventy-five (75) degrees Fahrenheit during the winter; or
    (b) Sixty-eight (68) to eighty-two (82) degrees Fahrenheit during the summer months.

27. Outdoor activity shall be restricted based upon:
    (a) Temperature;
    (b) Weather conditions; or
    (c) Weather alerts, advisories, and warnings issued by the National Weather Service.
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(19) [479] The Department of Housing, Buildings and Construction, State Fire Marshal’s Office, and cabinet shall be contacted concerning a planned new building, addition, or major renovation prior to construction.

(20) [480] An outdoor play area shall be:

(a) Except for an after-school child-care program, located on the premises of a public or state-accredited nonpublic school and fenced for the safety of the children;

(b) A minimum of sixty (60) square feet per child, separate from and in addition to the thirty-five (35) square feet minimum pursuant to subsection (b)(2) of this section;

(c) Free from:
   1. Litter;
   2. Glass;
   3. Rubbish; and
   4. Flammable materials;

(d) Safe from foreseeable hazard;

(e) Well drained;

(f) In good repair; and

(g) Visible to staff at all times.

(21) [481] A protective surface shall:

(a) Be provided for outdoor play equipment used to:
   1. Climb;
   2. Swing; and
   3. Slide; and

(b) Have a fall zone equal to the height of the equipment.

(22) [482] If a child-care center does not have access to an outdoor play area, an indoor space shall:

(a) Be used as a play area;

(b) Have a minimum of sixty (60) square feet per child, separate from and in addition to the thirty-five (35) square feet minimum pursuant to subsection (b)(2) of this section;

(c) Include equipment for gross motor skills;

(d) Be well-ventilated;

(e) Be heated; and

(f) Have a protective surface of at least two (2) inches thick around equipment intended for climbing.

(23) [483] Fences shall be:

(a) Constructed of safe material;

(b) Stable; and

(c) In good condition.

(24) [484] Supports for climbing apparatus and large equipment shall be securely fastened to the ground.

(25) [485] Crawl spaces, such as tunnels, shall be short and wide enough to permit access by adults.

(26) [486] A sandbox shall be:

(a) Constructed to allow for drainage;

(b) Covered when not in use;

(c) Kept clean; and

(d) Checked for vermin prior to use.

(27) [487] Bodies of water that shall not be utilized include:

(a) Portable wading pools;

(b) Natural bodies of water;

(c) Unfiltered, nondisinfected containers.

(28) [488] A child-care center shall have enough toys, play apparatus, and developmentally appropriate materials to provide each child with a variety of activities during the day, as specified in Section 2 of this administrative regulation.

(29) [489] Storage space shall be provided:

(a) In the form of:
   1. Shelves; or
   2. Other storage device accessible to the children; and

(b) In sufficient quantity for each child’s belongings;

(30) [490] Supplies shall be stored so that the adult can reach them without leaving a child unattended.

Section 5. Infant and Toddler Play Requirements. (1) Infant and toddler inside areas shall:

(a) Be separate from an area used by an older child;

(b) Not be an exit or entrance; and

(c) Have adequate crawling space for an infant or toddler away from general traffic patterns of the center.

(2) Except in accordance with subsection (3) of this section, an infant or toddler shall not participate in an activity with an older child for more than one (1) hour per day.

(3) A toddler may participate in an activity with an older child for more than one (1) hour per day if:

(a) The toddler is in transition to the pre-school age group;

(b) The toddler is twenty-one (21) months or older;

(c) Space for the toddler is available in the preschool age group;

(d) The staff-to-child ratios and group sizes are maintained based on the age of the youngest child;

(e) The center has a procedure for listing a transitioning toddler on attendance records, including a specific day and time the toddler is with either age group; and

(f) The child care center has obtained the signature and approval of the toddler’s parent on the toddler’s transition plan.

(4) If a child-care center provides an outdoor play area for an infant or toddler, the outdoor area shall be:

(a) Shaded; and

(b) A separate area or scheduled at a different time than an older child.

(5) Playpens and play yards shall:

(a) Meet federal standards as issued by the Consumer Product Safety Commission, including 16 C.F.R. 1221;

(b) Be manufactured for commercial use; and

(c) Not be used for sleeping or napping.

Section 6. Sleeping and Napping Requirements. (1) An infant shall sleep or nap on the infant’s back unless the infant’s health professional signs a waiver that states the infant requires an alternate sleeping position.

(2) Rest time shall be provided for each child who is not school-age and who is in care for more than four (4) hours.

(3) Rest time shall include adequate space specified by the child’s age as follows:

(a) For an infant:
   1. An individual non-tiered crib that meets Consumer Product Safety Commission standards established in 16 C.F.R. 1219-1220;
   2. A firm crib mattress in good repair with a clean tight-fitted sheet that shall be changed:
      a. Weekly; or
      b. Immediately if it is soiled or wet;
   3. No positioning device or monitor unless the device or monitor is required by the infant’s parent or health professional;
   4. No loose bedding; and
   5. No toys or other items except the infant’s pacifier or:
      (a) For a toddler or preschool-age child:
         1. An individual bed, a two (2) inch thick waterproof mat, or cot in good repair; and
         2. Bedding that is in good repair and is changed:
            a. Weekly; or
            b. Immediately if it is soiled or wet;
   6. Rest time shall not exceed two (2) hours for a preschool-age child unless the child is attending the child-care center during nontraditional hours.

(5) A child who does not sleep shall be permitted to play quietly and shall be visually supervised.

(6) Cots, equipment, and furnishings used for sleeping and napping shall be spaced twelve (12) inches apart to allow free and safe movement by a person.

(7) If cots or mats are used, floors shall be free from:

(a) Drafts;

(b) Liquid substances;

(c) Dirt; and

(d) Dampness.

(8) Cots or mats not labeled for individual use by a child shall be sanitized after each use.

(9) Individual bedding shall be stored in a sanitary manner.

An individual cot, crib, baby bed, or two (2) inch thick waterproof mat shall be provided for each child in attendance for more than three and one-half (3 1/2) hours per day.

(2) A crib shall:
(a) Be equipped with a firm, comfortable waterproof mattress; and
(b) Meet the standards set forth in 16 C.F.R. 1508 and 1509.
(2) Individual sheets and covers shall be:
(a) Provided for a child;
(b) Laundered a minimum of once per week or more often, if necessary; and
(c) Stored in a sanitary manner.
(4) If cots or mats are used, floors shall be free from:
(a) Drafts;
(b) Liquid substances;
(c) Dirt; and
(d) Dampness.
(5) Cots, other equipment, and furnishings shall be spaced twelve (12) inches apart to allow free and safe movement by a person.
(a) A tiered crib shall not be used.
(7) Cots or mats not labeled for individual use by a child shall be sanitized after each use.
(b) Cots or mats shall not be ripped or torn.

Section 7. First Aid and Medicine. (1) First aid supplies shall:
(a) Be available to provide prompt and proper first aid treatment;
(b) Be stored out of reach of a child;
(c) Be periodically inventoried to ensure the supplies are current;
(d) If reusable, be:
1. Sanitized; and
2. Maintained in a sanitary manner; and
(e) Include:
1. Liquid soap;
2. Adhesive bandages;
3. Sterile gauze;
4. Medical tape;
5. Scissors;
6. A thermometer;
7. Flashlight;
8. Cold pack;
10. Disposable gloves; and
11. A cardiopulmonary resuscitation mouthpiece protector.
(2) A child showing signs of an illness or condition that may be communicable shall not be admitted to the regular child-care program.
(3) If a child becomes ill while at the child-care center:
(a) The child shall be placed in a supervised area isolated from the rest of the children;
(b) The parent shall be contacted immediately; and
(c) Arrangements shall be made to remove the child from the child-care center as soon as practicable.
(4) Prescription and nonprescription medication shall be administered to a child in care:
(a) With a daily written request of the child’s parent; and
(b) According to the directions or instructions on the medication’s label.
(5) Prescription medication shall not be administered to a child in care without a daily written request of the parent.
(5) Nonprescription medication:
(a) May be given to a child only with the written daily request of the:
1. Parent; or
2. Person exercising custodial control of the child; and
(b) Shall be administered according to the instructions on the label.
(6) The child-care center shall keep a written record of the administration of medication, including:
(a) Time of each dosage;
(b) Date;
(c) Amount; and
(d) Name of staff person giving the medication;
(e) Name of the child; and
(f) Name of the medication.
(6) Medication, including refrigerated medication, shall be:
(a) Stored in a separate and locked place, out of the reach of a child;
(b) Kept in the original bottle; and
(c) Properly labeled.
(7) Medication shall not be given to a child if the expiration date on the bottle has passed.

Section 8. Kitchen Requirements. (1) The kitchen shall:
(a) Be clean;
(b) Be equipped for [the] proper food;
1. Preservation;
2. Storage;
3. Preparation; and
4. Serving[Service] of food;
(c) Be adequately ventilated to the outside air; and
(d) Except in a Type II child-care center when a meal is not being prepared, not be used for the activity of a child.
(2) A child-care center required to have a food service permit shall be in compliance with 902 KAR 45:005 and this administrative regulation.
(3) A child shall be:
(a) Seated with sufficient room to manage food and tableware; and
(b) Supplied with individual eating utensils designed for use by a child.
(4) Convenient and suitable sanitized utensils shall be:
(a) Provided; and
(b) Used to minimize handling of food during preparation.
(5) A cold-storage facility used for storage of perishable food in a nonfrozen state shall:
(a) Have an indicating thermometer or other appropriate temperature measuring device;
(b) Be in a safe environment for preservation; and
(c) Be forty [(40)] forty-five [(45)] degrees Fahrenheit or below; or
(d) Be kept at a temperature of zero degrees Fahrenheit or below; and
(b) Thawed: [If potentially hazardous:]
1. [Thawed] At refrigerator temperatures;
2. [Thawed] Under cool, potable running water;
3. [Quick thawed] As part of the cooking process; or
4. [Thawed] By another method in accordance with the Department of Public Health’s food safety standards and permits, established in KRS Chapter 217.
(6) Equipment, utensils, and surfaces contacting food shall be:
(a) Smooth;
(b) Free of breaks, open seams, cracks, and chips;
(c) Accessible for cleaning; and
(d) Nontoxic.
(7) The following shall be clean and sanitary:
(a) Eating and drinking utensils;
(b) Kitchenware;
(c) Food contact surfaces of equipment;
(d) Food storage utensils;
(e) Food storage containers;
(f) Cooking surfaces of equipment; and
(g) Nonfood contact surfaces of equipment.
(8) A single-service item[article] shall be:
(a) Stored;
(b) Handled and dispensed in a sanitary manner; and
(c) Used only once.
(9) Bottles shall be:
(a) Individually labeled;
(b) Promptly refrigerated; and
(c) Covered when not in use; and
(d) Consumed within one (1) hour of being heated or removed from the refrigerator.

Section 9. Food and Meal Requirements. (1) Food shall be:
(a) Clean;
(b) Free from:
1. Spoilage;
2. Adulteration; and
3. Misbranding;
(c) Safe for human consumption;
(d) Withheld from service or discarded if the food is hermetically sealed, nonacidic, or low-acidic food that has been processed in a place other than a commercial food-processing establishment;
(e) Obtained from a source that is in compliance with the Department of Public Health's food safety standards and permits, established in KRS Chapter 217;
(f) Acceptable if from an established commercial food store;
(g) Served in a quantity that is developmentally appropriate for the child with additional portions provided upon request of the child; and
(h) Protected against contamination from:
   1. Dust;
   2. Flies;
   3. Rodents and other vermin;
   4. Unclean utensils and work surfaces;
   5. Unnecessary handling;
   6. Coughs and sneezes;
   7. Cuts in skin;
   8. Communicable disease;
   9. Flooding;
 10. Drainage; and
11. Overhead leakage.
(2) Food shall not be:
(a) Used for reward;
(b) Used for discipline;
(c) Withheld until all other foods are consumed; or
(d) Served while viewing electronic devices.
(3) A serving of milk shall consist of:
(a) Breast milk or iron-fortified formula for a child age birth through twelve (12) months;
(b) Pasteurized whole milk for children ages thirteen (13) months to twenty-four (24) months; or
(c) Pasteurized low fat one (1) percent or fat-free skim milk for children ages twenty-five (25) months to twelve (12) years of age.
(4) Formula or breast milk shall be prepared, labeled, and provided by the parent.
(5) A child-care center may participate in the Child and Adult Care Food Program (CACFP).
(6) A serving of bread shall only consist of whole or enriched grain.
(7) Drinking water shall be freely available to a child throughout the day.
(8) Food shall be stored on:
(a) Clean racks;
(b) Clean shelves;
(c) Other clean surfaces; or
(d) If maintained in a sanitary condition, in nonabsorbent labeled containers a minimum of six (6) inches off the floor.
(9) Fruits and vegetables shall be washed before cooking or serving.
(10) Meat salads, poultry salads, and cream-filled pastries shall be:
(a) Prepared with utensils that are clean; and
(b) Refrigerated unless served immediately.
(11) An individual portion of food served to a child or adult shall not be served again.
(12) Wrapped food that is still wholesome and has not been unwrapped may be reserved.
(13) Meals shall be:
(a) Served every two (2) to three (3) hours; and
(b) Served to a child:
   1. Seated with sufficient room to manage food and tableware; and
   2. Supplied with individual eating utensils designed for use by a child.
(14) All children shall be offered the same food items unless the child's parent or health professional documents a dietary restriction that necessitates an alternative food item for the child.
(15) A child-care center shall serve:
(a) Breakfast; or
2. A mid-morning snack.
Section 10. Toilet, Diapering, and Toiletry Requirements. (1) A child-care center shall have a minimum of one (1) toilet and one (1) lavatory for each twenty (20) children. Urinals may be substituted for up to one-half (1/2) of the number of toilets required for a male toilet room.

(2) A toilet room shall:
   (a) Be provided for each gender; or
   (b) A plan shall be implemented to use the same toilet room at separate times;

   (b) Have a supply of toilet paper; and
   (c) Be cleaned and sanitized daily.

(3) A sink shall be: [c]

(a) Located in or immediately adjacent to toilet rooms;
(b) Equipped with hot and cold running water that allows for
   hand washing;
(c) Equipped with hot water at a minimum temperature of ninety (90) degrees Fahrenheit and a maximum of 120[no more than 110] degrees Fahrenheit;
(d) Equipped with liquid soap;
(e) Equipped with hand-drying blower or [and] single use disposable hand drying material;
(f) Equipped with an easily cleanable, covered waste receptacle; and
(g) Immediately adjacent to a changing area used for infants and toddlers.

(4) Each toilet shall:
   (a) Be kept in clean condition;
   (b) Be kept in good repair;
   (c) Be in a lighted room; and
   (d) Have ventilation to outside air.

(5) Toilet training shall be coordinated with the child’s parent.

(6) An adequate quantity of freshly laundered or disposable diapers and clean clothing shall be available.

(7) If a toilet training chair is used, the chair shall be:
   (a) Used over a surface that is impervious to moisture;
   (b) Out of reach of other toilets or toilet training chairs;
   (c) Emptied promptly; and
   (d) Sanitized after each use.

(8) Diapers or clothing shall be:
   (a) Changed when soiled or wet;
   (b) Stored in a covered container temporarily; and
   (c) Washed or disposed of at least once a day.

(9) The proper methods of diapering and hand-washing shall
   be posted at each diaper changing area.

(10) When a child is diapered, the child shall:
   (a) Not be left unattended; and
   (b) Be placed on a surface that is:
       1. Clean;
       2. Padded;
       3. Free of holes, rips, tears, or other damage;
       4. Nonabsorbent;
       5. Easily cleaned; and
       6. Free of any items not used for diaper changing.

(11) Unless allergic, individual disposable washcloths shall be used to thoroughly clean the affected area of the child.

(12) Staff shall disinfect the diapering surface after each child
   is diapered.

(13) If staff wear disposable gloves, the gloves shall be
   changed and disposed after each child is diapered.

(14) Combs, towels or washcloths, brushes, and toothbrushes
   used by a child shall be:
   (a) Individually stored in separate containers; and
   (b) Plainly labeled with the child’s name.

(15) Toothbrushes shall be:
   (a) Individually identified;
   (b) Allowed to air dry; and
   (c) Protected from contamination.

(16) Toothpaste used by multiple children shall be dispensed
   onto an intermediate surface, such as waxed paper, to avoid cross
   contamination.

Section 11. Toys and Furnishings. (1) All toys, equipment, and
   furniture contacted by a child shall be:
   (a) Kept clean and in good repair; and
   (b) Free of peeling, flaking, or chalking paint.

(2) Indoor and outdoor equipment shall:
   (a) Be clean, safe, and in good repair;
   (b) Meet the physical, developmental needs, and interests of
   children of different age groups;
   (c) Be free from sharp points or corners, splinters, protruding
   nails or bolts, loose or rusty parts, hazardous small parts, lead-
   based paint, poisonous material, and flaking or chalking paint;
   and
   (d) Be designed to guard against entrapment or situations that
   may cause strangulation.

(3) Toys shall be:
   (a) Used according to the manufacturer’s safety specifications;
   (b) Durable; and
   (c) Without sharp points or edges.

(4) Toys and other items that are considered mouth contact
   surfaces by a child not toilet trained shall be sanitized daily by:
   (a) Scrubbing in warm, soapy water using a brush to reach into
   crevices;
   (b) Rinsing in clean water;
   (c) Submerging in a sanitizing solution for at least two (2) mi-
   nutes; and
   (d) Air dried.

(5) Tables and chairs shall be of suitable size for children.

(6) Chairs appropriate for staff shall be provided to use when
   feeding, holding, or playing with a child.

Section 12. Transportation. (1) A center shall document com-
pliance with KRS Chapter 186 and 603 KAR 5:072 pertaining to:
   (a) Vehicles;
   (b) Drivers; and
   (c) Insurance.

(2) A center providing or arranging transportation service shall:
   (a) Be licensed and approved by the cabinet or its designee
   prior to transporting a child;
(b) Have a written plan that details the type of transportation, staff schedule, transportation schedule, and transportation route; and

(c) Have written policies and procedures, including emergency procedures practiced monthly by staff who[that] transport children.

(3) Prior to transporting a child, a center providing transportation services of a child shall notify the cabinet or its designee in writing of the:

(a) Type of transportation offered;
(b) Type of vehicle used for transportation;
(c) Plan for ensuring staff perform duties relating to transportation properly;
(d) Full insurance coverage for each vehicle;
(e) Agency policy and procedures relating to an emergency plan for evacuating the vehicle;
(f) Contracts, agreements, or documents detailing arrangements with any third party for services; and

(g) Safety procedures for:
1. Transferring a child;
2. Loading and unloading a child; and
3. Providing adequate supervision of a child.

(4) A vehicle used to transport children shall be equipped with:

(a) A fire extinguisher;
(b) First aid supplies as described in Section 7 of this administrative regulation;
(c) Emergency reflective triangles; and
(d) A device to cut the restraint system, if necessary.

(5) Transportation provided by licensed public transportation or a school bus shall comply with subsections (1) and (2) of this section.

(6) A vehicle used to transport children shall meet the following requirements:

(a) A twelve (12) or more passenger vehicle shall display a current certification of inspection from the Transportation Cabinet on the designated window.

(b) A vehicle that requires traffic to stop while loading and unloading a child shall be equipped with a system of:
1. Signal lamps;
2. Identifying colors; and
3. Cautionary words.

(c) A vehicle shall be equipped with seat belts for each occupant to be individually secured.

(d) A vehicle shall not transport children and hazardous materials at the same time.

(7) The appropriate car safety seat meeting federal and state motor vehicle safety standards in 49 C.F.R. 571.213 and KRS 189.125(189.285) shall be used for each child.

(8) A daily inspection of the vehicle shall be performed and documented for the following:

(a) Tires;
(b) Lights, signals, mirrors, gauges, and wiper blades;
(c) Safety restraints;
(d) Fuel; and
(e) Free of debris.

(9)(a) The staff-to-child ratios set forth in Section 2(2) of this administrative regulation shall apply to vehicle transport, if not inconsistent with special requirements or exceptions in this section.

(b) An individual who is driving with a child in the vehicle shall
1. Hold a current driver's license which has not been suspended or revoked during the last five (5) years; and
2. Be completed by a staff member other than the driver; and
3. Emergency brake shall be set.

(10) Each child shall:

(a) Have a seat;
(b) Be individually belted or harnessed in the seat; and
(c) Remain seated while the vehicle is in motion.

(11) A child shall not be left:

(a) Unattended at the site of aftercare delivery; and
(b) Unattended in a vehicle.

(12) If the parent or designee is unavailable, a prearranged written plan shall be completed to designate where the child can be picked up.

(13) A child shall not be picked up or delivered to a location that requires crossing the street or highway unless accompanied by an adult.

(14) A vehicle transporting a child shall have the headlamps on.

(15) If a vehicle needs to be refueled, it[4] shall be refueled when not being used to transport a child. If emergency refueling or repair is necessary during transporting, all children shall be removed and supervised by an adequate number of adults while refueling or repair is occurring.

16) If the driver is not in the driver's seat, the:

(a) Engine shall be turned off;
(b) Keys shall be removed; and
(c) Emergency brake shall be set.

(17) Transportation services provided shall:

(a) Be recorded in writing and include:
1. The first and last name of the child transported; and
2. The time each child gets on and the time each child gets off;
(b) Be completed by a staff member other than the driver; and
(c) Be kept for five (5) years.

(18) A driver of a vehicle transporting a child for a center shall:

(a) Be at least twenty one (21) years old;
(b) Complete the background checks as described in 922 KAR 2:082.

(c) Hold a current driver's license which has not been suspended or revoked during the last five (5) years; and

(d) Not have had any convictions concerning vehicle operation in the past twelve (12) months; and

(e) Not caused an accident which resulted in the death of a person.

(19) Firearms [Guns], ammunition, alcohol, or illegal substances shall not be transported in a vehicle transporting children.

Section 13. Animals. (1) An animal shall not be allowed in the presence of a child in care:

(a) Unless:
1. The animal is under the supervision and control of an adult;
2. Written parental consent has been obtained; and
3. The animal is certified as vaccinated against rabies; or
(b) Except in accordance with subsection (3) of this section.
Animals shall be:

(a) Supervised by an adult if in the presence of a child in care; and
(b) Certified as properly vaccinated against rabies.

(2) A parent shall be notified in writing if a child has been bitten or scratched by an animal.

(3) An animal that is considered undomesticated, wild, or exotic shall not be allowed at a child-care center unless the animal is:

(a) A part of a planned program activity lead by an animal specialist affiliated with a zoo or nature conservatory; and
(b) In accordance with 301 KAR 2:081 and 301 KAR 2:082. [Except if used as planned program activity in the control of an animal specialist, an animal that is considered undomesticated, wild, or exotic shall not be allowed at a child-care center.]

TERESA C. JAMES, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: September 13, 2012
FILED WITH LRC: September 13, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Child Care
(As Amended at ARRS, January 7, 2013)

922 KAR 2:180. Requirements for registered child care providers in the Child Care Assistance Program.


STATUTORY AUTHORITY: KRS 194A.050(1), 199.899(6)

NECESSITY, FUNCTION, AND CONFORMITY: KRS
Section 1. Definitions. (1) “Address check” means a cabinet search of the Sex Offender Registry to determine if a person’s residence is a known address of a registered sex offender.

(2) “Cabinet” is defined by KRS 199.011(2).

(3) “Child” is defined by KRS 199.011(4) and may include a minor:

(a) Thirteen (13) years of age; or
(b) Eighteen (18) years of age if the minor has a special need for which supervision is required.

(4)(12) “Closed” means the provider is no longer a registered program provider.

(5) “Conditional Approval” means time-limited approval while completing required training.

(6) “Corporal physical discipline” is defined by KRS 314.011(5).

(7)(13) “Denied” means the application for program registration is not approved and the applicant will be penalized.

(8) “Developmentally appropriate” means suitable for the specific age range and abilities of a child.

(9)(14) “Health professional” means a person actively licensed in Kentucky as:

(a) Physician;
(b) Physician’s assistant;
(c) Advanced registered nurse practitioner; or
(d) Registered nurse as defined in KRS 314.011(5) under the supervision of a physician.

(10) “Related” means having one (1) of the following relationships with the registered provider:

(a) Child;
(b) Grandchild;
(c) Niece;
(d) Nephew;
(e) Sibling;
(f) Step-child; or
(g) Child in legal custody of the provider.

(11) “Parent” is defined by 45 C.F.R. 98.2.

(12) “Pediatric abusive head trauma” is defined in KRS 620.020(6).

(13)(5)(a) “Revoked” means the provider is no longer a registered provider and the provider will be penalized.

(14) “Sex Offender Registry” means the registration system for adults who have committed sex crimes or crimes against minors established in accordance with KRS 17.500 through 17.580.

(15)(14) “Withdrawn” means the application for program registration is removed from consideration without a penalty.

Section 2. Application Rights and Requirements for Child Care Provider Registration. (1) An individual shall notify the cabinet or its designee of the individual’s intent to apply for child care provider registration:

(a) Directly by:

1. Telephone; or
2. Written statement; or
(b) Indirectly by being designated as the choice for providing unregulated child care by an applicant for benefits under the Child Care Assistance Program (CCAP) in accordance with KRS 199.8994(6) and as defined in KRS 922 KAR 2:160, Section 1(16).

(2) An individual may apply or reapply for child care provider registration on the same day that the notice of intent to apply in accordance with subsection (1) of this section is made with the cabinet or its designee.

(3) An individual who intends and requests to apply for registration as a child care provider shall not be required to appear in person to complete an application and supporting documentation in accordance with subsections (4) and (5) of this section, but may receive all necessary forms and instructions by mail.

(4) To apply for child care provider registration in CCAP, an individual shall, within thirty (30) calendar days of giving notice of intent to apply pursuant to subsection (1) of this section:

(a) Submit:

1. A completed DCC-95, Application for Registered Child Care Provider in Provider’s Home; or
b. A completed DCC-96, Application for Registered Child Care Provider in Child’s Home;

2. Written verification from a health professional that the individual is:

(a) Free of active tuberculosis; and
(b) In good general health and able to care for children.

3. A completed DCC-94A, Registered Child Care Provider Information Form; [and]

4. A completed IRS W-9, the Request for Taxpayer Identification Number and Certification; and

5. A written evacuation plan in the event of fire, natural disaster, or other threatening situation that may pose a health or safety hazard to a child in care that includes:

(a) A designated relocation site;
(b) Evacuation routes;
(c) Measures for notifying parents of the relocation site and ensuring a child’s return to the child’s parent; and
(d) Actions to address the needs of an individual child to include a child with a special need. The cabinet shall post an online template of an evacuation plan that fulfills requirements of this administrative regulation for an individual’s free and optional use;

(b) Show proof by photo identification or birth certificate that the individual is eighteen (18) years or older;
(c) Show verification of Social Security number; and
(d) Meet the requirements of KRS 17.165(5), as shown by providing:

1. A criminal records check conducted by the Kentucky State Police or the Administrative Office of the Courts within the previous twelve (12) months on the individual;
2. A child abuse and neglect check using the central registry in accordance with KRS22 KAR 1:470; and
3. A criminal records check for any previous state of residence completed once if:

a. The applicant resided outside the state of Kentucky in the last five (5) years; and
b. No criminal records check has been completed for the applicant’s previous state of residence; and

4. Permission to conduct an address check of the Sex Offender Registry (Provision of the criminal records and child abuse and neglect check results, conducted pursuant to subparagraphs 1 and 2 of this paragraph, to the cabinet or its designee);

(5)(a) An applicant may receive conditional approval in accordance with Section 4(2) of this administrative regulation.

(b) Within ninety (90) calendar days of giving notice of intent to apply for registration as a child care provider in CCAP pursuant to subsection (1) of this section, the applicant shall provide verification that the applicant has obtained three (3) hours of training approved by the cabinet or its designee, in the areas of:

1. Health, safety, and sanitation (Infant and child first aid);
2. Recognition of child abuse and neglect, which may include cabinet-approved pediatric abusive head trauma training in accordance with KRS 199.896(16) and as defined in KRS 922 KAR 2:160, Section 1(16).

(2) An individual may apply or reapply for child care provider registration in accordance with subsection (1) of this section by:

(a) A completed DCC-95, Application for Registered Child Care Provider in Provider’s Home; or
b. A completed DCC-96, Application for Registered Child Care Provider in Child’s Home;

2. Written verification from a health professional that the individual is:

(a) Free of active tuberculosis; and
(b) In good general health and able to care for children.

3. A completed DCC-94A, Registered Child Care Provider Information Form; [and]

4. A completed IRS W-9, the Request for Taxpayer Identification Number and Certification; and

5. A written evacuation plan in the event of fire, natural disaster, or other threatening situation that may pose a health or safety hazard to a child in care that includes:

(a) A designated relocation site;
(b) Evacuation routes;
(c) Measures for notifying parents of the relocation site and ensuring a child’s return to the child’s parent; and
(d) Actions to address the needs of an individual child to include a child with a special need. The cabinet shall post an online template of an evacuation plan that fulfills requirements of this administrative regulation for an individual’s free and optional use;

(b) Show proof by photo identification or birth certificate that the individual is eighteen (18) years or older;
(c) Show verification of Social Security number; and
(d) Meet the requirements of KRS 17.165(5), as shown by providing:

1. A criminal records check conducted by the Kentucky State Police or the Administrative Office of the Courts within the previous twelve (12) months on the individual;
2. A child abuse and neglect check using the central registry in accordance with KRS22 KAR 1:470; and
3. A criminal records check for any previous state of residence completed once if:

a. The applicant resided outside the state of Kentucky in the last five (5) years; and
b. No criminal records check has been completed for the applicant’s previous state of residence; and

4. Permission to conduct an address check of the Sex Offender Registry (Provision of the criminal records and child abuse and neglect check results, conducted pursuant to subparagraphs 1 and 2 of this paragraph, to the cabinet or its designee);

(5)(a) An applicant may receive conditional approval in accordance with Section 4(2) of this administrative regulation.

(b) Within ninety (90) calendar days of giving notice of intent to apply for registration as a child care provider in CCAP pursuant to subsection (1) of this section, the applicant shall provide verification that the applicant has obtained three (3) hours of training approved by the cabinet or its designee, in the areas of:

1. Health, safety, and sanitation (Infant and child first aid);
2. Recognition of child abuse and neglect, which may include cabinet-approved pediatric abusive head trauma training in accordance with KRS 199.896(16) and as defined in KRS 922 KAR 2:160, Section 1(16).

Section 3. Additional Requirements for Registered Providers in
Provider's Home. (1) If a registered child care provider provides child care services in the provider's home;
   a. The provider shall:
      1. (a) Submit written verification from a health professional that each member of the provider's household age eighteen (18) or older is free from tuberculosis; and
      2. (b) Provide written verification that each member of the provider's household who is age eighteen (18) or older meets the requirements in KRS 17.165 by the member's provision of the following to the cabinet or its designee:submitted to a:
        a. (1) Criminal records check conducted by the Kentucky State Police or the Administrative Office of the Courts;
        b. Criminal records check for any previous state of residence completed once if:
           (i) The household member resided outside the state of Kentucky in the last five (5) years; and
           (ii) No criminal records check has been completed for the household member's previous state of residence; and
        c. Child care provider through the cabinet or its designee:
           (1) Background check using the central registry in accordance with 922 KAR 1:470;
           (2) An address check of the Sex Offender Registry and supporting documentation shall confirm that no individual residing in the provider's household is a registered sex offender; and
           (3) Provision of the criminal records and child abuse and neglect checks conducted pursuant to subparagraphs 1 and 2 of this paragraph, to the cabinet or its designee;
      (2) A registered child care provider shall certify that the provider's home and each play area used for child care are safe and adequate:
         (a) Heat;
         (b) Light; and
         (c) Ventilation.
      (3) Each floor of the registered child care provider's home used for child care shall have at least one (1):
         (a) Unblocked exit to the outside;
         (b) Smoke detector;
         (c) Fire extinguisher; and
         (d) Carbon monoxide detector if the home:
            1. Uses fuel burning appliances; or
            2. Has an attached garage.
      (4) A registered child care provider's home shall have a:
         (a) Refrigerator in working order that maintains a temperature of forty-five (45) degrees Fahrenheit or below; and
         (b) Freezer that maintains a temperature of zero degrees Fahrenheit.
      (5) A registered child care provider shall maintain first aid supplies that include:
         (a) Liquid soap;
         (b) Band aids;
         (c) Sterile gauze; and
         (d) Adhesive tape.
      (6) The registered child care provider shall wash hands with liquid soap and running water:
         (a) Before and after diapering a child;
         (b) Before and after food preparation;
         (c) Before feeding a child; and
         (d) At other times when necessary to prevent the spread of disease.
      (7) In accordance with KRS 199.896(18), a registered child care provider shall not use corporal physical discipline on a child entrusted to the provider's care.
      (8) Pets or livestock shall be vaccinated and not left alone with a child.
      (9) If transportation is provided by a registered child care provider, the registered child care provider shall:
         (a) Have written permission from a parent or guardian to transport the child;
         (b) Have a vehicle equipped with seat belts; and
         (c) Comply with KRS 189.125 regarding child restraint and seating:
            Ensure that each child over forty (40) inches in height is restrained in accordance with Kentucky law; and
         (d) Comply with KRS 189.125(3) for each child forty (40) inches in height or less and comply with 189.125(b).
   b. Sections 2(4), (5), and 6 of this administrative regulation.
   c. The cabinet or its designee shall approve, deny, or withdraw an individual's application for registration within thirty (30) days:
      (1) After receipt of the individual's notice of intent to apply made in accordance with Section 2(1) of this administrative regulation.
      (2) The cabinet or its designee may conditionally approve an individual who made a notice and application pursuant to Section 2(1) and (4) of this administrative regulation, to provide child care services to a child for ninety (90) calendar days, if the applicant meets the requirements of:
         (a) Sections 2(4), (5), and 6 of this administrative regulation;
         (b) Section 3 of this administrative regulation, if child care is given in the home of the provider;
      (3) The cabinet or its designee shall approve an individual who made a notice and application pursuant to Section 2(1) and (4) of this administrative regulation as a registered child care provider for one (1) year, if the applicant meets the requirements specified in:
         (a) Sections 2(4) through (5)(6), and 5, and 6 of this administrative regulation;
         (b) Section 3 of this administrative regulation if child care is given in the home of the provider.
      (4) If a conditionally approved provider, as specified in subsection (2) of this section, has not completed the training requirement within the ninety (90) day timeframe pursuant to Section 2(5)(4) of this administrative regulation, the cabinet or its designee shall:
         (a) Not approve an applicant for payment pursuant to 922 KAR 2:160 past the ninety (90) days of conditional approval; and
         (b) Deny another:
            1. Period of conditional approval for the same applicant; or
            2. Application from the same applicant unless training has been completed in accordance with Section 2(5) of this administrative regulation.
   d. The cabinet may confirm training verification provided by an applicant, conditionally approved applicant, or registered child care provider through the cabinet-approved training database maintained in accordance with 922 KAR 2:240.

Section 5. General Requirements for Registered Child Care
Providers. (1) A registered child care provider shall not:
(a) Live in the same residence as the child in care;
(b) Hold a license to provide child care in accordance with 922 KAR 2:100;
(c) Hold certification to provide child care in accordance with 922 KAR 2:100; or
(d) Provide care for more than three (3) children unrelated to the provider in accordance with KRS 199.8982(1)(a).
(2) A registered child care provider shall not provide other home based services, including [such] services, such as:
(a) A personal care home in accordance with 902 KAR 20:036;
(b) A family home care in accordance with 902 KAR 20:041;
(c) An adult day care in accordance with 910 KAR 1:160; or
(d) Supports for community living in accordance with 907 KAR 1:145.
(3) A registered child care provider shall:
(a) Comply with the:
1. Provisions of KRS 199.898; and
2. Provider requirements in accordance with 922 KAR 2:160, Section 13;
(b) Allow the cabinet, its designee, and parent access to the premises where a child receives care during the hours that the child care services are provided; and
(c) Report within ten (10) calendar days any change to the provider’s:
1. Address;
2. Name;
3. Telephone number;
4. Household members; or
5. Location where the child care is provided.
(4) A registered child care provider who gives care in the provider’s home shall comply with the requirements of Section 3(1) of this administrative regulation with ten (10) calendar days for a:
(a) New household member who is eighteen (18) years old or younger;
(b) Household member who turns age eighteen (18).
(5)(a) A registered child care provider shall maintain a [monthly] sign-in sheet in which the daily arrival and departure times of each child are recorded in accordance with 922 KAR 2:160, Section 13.
(b) A registered child care provider shall retain [monthly] sign-in sheets completed in accordance with paragraph (a) of this subsection for five (5) years.
(6)(a) Care for a child with a special need shall be consistent with the nature of the need as documented by the child’s health professional.
(b) A child may include a person eighteen (18) years of age if the person has a special need for which child care is required.
(7) While providing child care services, a registered provider and another person in the provider’s home shall:
(a) Be free of the influence of alcohol or a controlled substance, except for use of a controlled substance as prescribed by a physician; and
(b) Prohibit smoking in the presence of a child in care.
(8) A registered child care provider shall report to the cabinet or designee:
(a) Within twenty-four (24) hours from the time of discovery:
1. A communicable disease, which shall also be reported to the local health department pursuant to KRS 214.010;
2. An accident or injury to a child that requires medical care;
3. An incident that results in legal action by or against the registered child care provider that affects:
   a. A child in care;
   b. The registered child care provider; or
   c. An adult residing in the registered child care provider’s household if child care services are provided in the provider’s home;
4. An incident involving a fire or other emergency; or
5. A report of child abuse or neglect that:
   a. Has been accepted by the cabinet in accordance with 922 KAR 1:330; and
   b. Names:
   (i) The registered child care provider as the alleged perpetrator; or
   (ii) A member of the registered child care provider’s household as alleged perpetrator if child care services are provided in the provider’s home;
(b) An incident of child abuse or neglect pursuant to KRS 620.030;
(c) The death of a child in care within one (1) hour; or
(d) The provider’s temporary or permanent closure as soon as practicable, which shall also be given to the parent of a child in care.
Section 6. Child Ratios. During hours of operation, a registered child care provider shall not care for more than:
(1) Three (3) children receiving CCAP per day,[ae]
(2) Six (6) children receiving CCAP per day, if those children are:
   a. A part of a sibling group; and
   b. Related to the provider; or
(3) A total of eight (8) children inclusive of the provider’s own children.
Section 7. Renewal of Registration. (1) The cabinet or its designee shall send a reminder notice to a registered child care provider at least forty-five (45) calendar days prior to the expiration date of the provider’s registration issued in accordance with Section 4(3) of this administrative regulation.
(2) To renew child care provider registration prior to the expiration of the registration, a registered child care provider shall:
(a) Meet the requirements specified in Sections 2(4)(b) and 5, and 6 of this administrative regulation;[and]
(b) Complete, and provide verification of, three (3) hours of training in early care and education approved by the cabinet or its designee.
1. To include one and one-half (1 1/2) hours of pediatric abusive head trauma training:
   a. Within first year of employment or operation as a child care provider; and
   b. Completed once during each subsequent five (5) years of employment or operation as a child care provider[.]
2. In one (1) or more of the following subjects:
   a.[l] Child growth and development;
   b.[2] Learning environments and nutrition;
   c.[3] Health, safety, and nutrition;
   d.[4] Family and community partnerships;
   e.[5] Child assessment;
   f.[6] Professional development and professionalism; or
   g.[7] Program management and evaluation;
(c) Submit an updated version of the evacuation plan described in Section 2(4)(a) of this administrative regulation;
(d) Retain a copy of the updated evacuation plan; and
(e) Provide a copy of the updated evacuation plan to each parent of a child in care.
(3) In addition to the requirements of subsection (2) of this section, a registered provider who gives care in the provider’s home shall also meet the requirements of Section 3 of this administrative regulation.
Section 8. Negative Action for an Applicant or a Registered Child Care Provider. (1) If a registered child care provider or a member of the provider’s household is named as the alleged perpetrator in a child abuse or neglect report accepted by the cabinet in accordance with 922 KAR 1:330, the individual shall be removed from direct contact with a child in care:
(a) For the duration of the family-in-need-of-services assessment or investigation; and
(b) Pending completion of an administrative appeal process for a cabinet substantiation of child abuse or neglect in accordance with 922 KAR 1:320 or 922 KAR 1:480.
(2) The cabinet or its designee shall send written notice of negative action to:
(a) An applicant for registration, if the application is:
   1. Withdrawn; or
   2. Denied; or
(b) A registered child care provider, if the provider’s registration is:
1. Closed; or
2. Revoked.

The notice of negative action shall include the:
(a) Reason for the negative action; and
(b) Effective date.

An application for registration shall be denied or a registered provider’s registration shall be revoked if:
(a) Written verification from a health professional confirms a diagnosis of tuberculosis;
(b) A background check pursuant to KRS 17.165(5) reveals a:
1. Substantiated incident of child abuse or neglect in accordance with 922 KAR 1:470; or
2. Conviction of:
   a. Violent crime; or
   b. Sex crime;
(c) A history of behavior exists that may impact the safety or security of a child in care including:
1. A conviction related to the abuse or neglect of an adult;
2. A conviction for a drug-related felony unless five (5) years have elapsed since the person was fully discharged from imprisonment, probation, or parole;
3. A confirmation through an address check and supporting documentation that:
   a. Provider is a registered sex offender; or
   b. Member of the provider’s household is a registered sex offender; or
   c. The provider provides child care services in the provider’s home; or
4. Other behavior or condition indicating inability to provide reliable care to a child;
(d) The provider uses or allows the use of any form of corporal physical discipline on a child entrusted to the provider’s care; or
(e) The cabinet has probable cause to believe there is an immediate threat to the health, safety, or welfare of a child.

An applicant or registered child care provider whose application has been denied or whose registration has been revoked by the cabinet or its designee as the result of a negative action stemming from the requirements specified in 922 KAR 2:090, 2:100, 2:110, 2:120, or this administrative regulation, shall not be eligible to apply, operate, or reapply for registration with CCAP for a penalty period of one (1) year from the date of denial, suspension, or revocation. After completion of the one (1) year penalty period from the date of prior denial, suspension, or revocation, an individual may be approved if the individual:
(a) Complies with:
1. Sections 2, 5, and 6 of this administrative regulation; and
2. If care is given in the home of the provider, Section 3 of this administrative regulation;
(b) Completes, and provides verification of, an additional twelve (12) hours of training approved by the cabinet or its designee in early care and education;
(c) Has not had an application, certificate, license, or registration to operate as a child care provider denied or revoked as specified in KRS 17.165; and
(d) Completes any disqualification period imposed from a previous denial, suspension, or revocation of providing child care services.

An application may be withdrawn:
(a) If all required documentation for the application process is not received within thirty (30) calendar days in accordance with Section 2(4) of this administrative regulation; or
(b) At the request of the applicant.

A registered child care provider’s status may be closed:
(a) At the request of the provider; or
(b) If the provider fails to comply with requirements in Section 3, 5, 6, or 7(2).

Section 9. Appeal of Negative Action. If the cabinet or its designee denies or revokes an application for registration, it revokes a provider’s registration, or closes a provider, the applicant or provider may request an appeal in accordance with 922 KAR 1:320.

Section 10. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) "DCC-94A Registered Child Care Provider Information Form", edition 7/12(11/07);
(b) "DCC-95, Application for Registered Child Care Provider in Provider’s Home", edition 7/12(11/07);
(c) "DCC-96, Application for Registered [Ins] Child Care Provider in Child’s Home", edition 7/12(11/07); and
(d) "IRS W-9, Request for Taxpayer Identification Number and Certification", edition 10/07(11/05).

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TERESA C. JAMES, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: September 13, 2012
FILED WITH LRC: September 13, 2012 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Child Care
(As Amended at ARRS, January 7, 2013)

922 KAR 2:190. Civil penalties.

RELATES TO: KRS Chapter 13B, 199.896, 199.990
STATUTORY AUTHORITY: KRS 194A.050(1), 199.896(2)

KRS 194A.050(1) requires the Secretary for the Cabinet for Health and Family Services to promulgate administrative regulations necessary to operate programs and fulfill responsibilities vested in the cabinet qualify for the receipt of federal funds, and cooperate with other states and federal agencies for the proper administration of the cabinet and its programs. KRS 199.896(2) authorizes the secretary to promulgate administrative regulations to establish procedures for enforcement of penalties. [KRS 199.896(4)] [authorize the Secretary of the cabinet to take emergency action in the event of an immediate threat to public health, safety, or welfare. KRS 199.990(4) establishes the penalties to be assessed for violations of KRS 199.896 that pose an immediate threat to the health, safety, or welfare of a child served by a child care center, child care facility, or child care home. KRS 199.896(7) establishes a right of appeal. The child care center or child care facility aggrieved by an action of the cabinet adverse to the center’s interests or the cabinet’s assessment of a civil penalty. This administrative regulation establishes the cabinet procedures for a civil penalty and appeal resulting from a child-care center’s violation to carry out the statutory provisions].

Section 1. Definitions. (1) "Cabinet" is defined by KRS 199.894(1).
2. "Child-care center" is defined by KRS 199.894(3).
3. "Licensee" means the owner and operator of a child-care center to include:
(a) Sole proprietor;
(b) Corporation;
(c) Limited liability company;
(d) Partnership;
(e) Association; or
(f) Organization, such as:
1. Board of education;
2. Private school;
3. Faith-based organization;
4. Government agency; or
5. Institution.
4. "Office of Inspector General" or "OIG" means the organizational unit of the cabinet established in accordance with KRS 194A.030(1)(c) or its designee.
5. "Statement of deficiency" means a finding of a regulatory
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noncompliance issued in accordance with 922 KAR 2:090, Section 9.

Section 2. Types of Violations. The cabinet shall issue a licensee a:

(1) Type A violation if:

(a) A child-care center violates a standard or a requirement specified in KRS 199.896, KRS 199.990(4), 922 KAR 2:090, 922 KAR 2:110, or 922 KAR 2:120; and

(b) The violation creates harm, an imminent threat, or an imminent danger to the health, safety, or welfare of a child in the center’s care, such as the center:

1. Failing to:
   a. Provide for the health, safety, or welfare of a child in care that results in injury to the child, the child’s hospitalization, or death of the child;
   b. Complete a criminal records check and a child abuse and neglect check required in accordance with:
      (i) 922 KAR 2:090, Section 6; or
      (ii) 922 KAR 2:110, Section 5;
   c. Remove a person with a substantiation of child abuse or neglect from contact with a child in care in accordance with:
      (i) 922 KAR 2:090, Section 6; or
      (ii) 922 KAR 2:110, Section 5;
   d. Comply with a suspension of services; or
   e. Administer discipline in accordance with 922 KAR 2:120, Section 2(8) or 2(10);

2. Falsifying records;

3. Operating contrary to approved licensed services;

4. Changing location without prior approval of the cabinet.

(2) Type B violation if:

(a) A child-care center violates a standard or requirement specified in KRS 199.896, KRS 199.990(4), 922 KAR 2:090, 922 KAR 2:110, or 922 KAR 2:120; and

(b) The violation presents a concern or risk to the health, safety, or welfare of a child in care, but does not create harm, an imminent threat, or an imminent danger to the child, such as the center:

1. Failing to:
   a. Complete one (1) of a person’s background checks required in accordance with:
      (i) 922 KAR 2:090, Section 6; or
      (ii) 922 KAR 2:110, Section 5;
   b. Respond to a child’s first aid and medical needs in accordance with 922 KAR 2:120, Section 7;
   c. Have staff currently certified in cardiopulmonary resuscitation and first aid in accordance with 922 KAR 2:110, Sections 5(3) through 5(6);
   d. Provide adequate supervision in accordance with 922 KAR 2:120, Section 2(3);
   e. Make toxic supplies inaccessible to a child in accordance with 922 KAR 2:120, Section 3(7); or
   f. Maintain sufficient records on a child in accordance with 922 KAR 2:110, Section 3;

2. Releasing a child to a person who is not designated by the child’s parent to pick up the child;

3. Leaving a child alone with an underage caregiver; or

4. Exceeding the staff-to-child ratios in 922 KAR 2:120, Section 2 by fifty (50) percent or more.

Section 3. Assessment of a Civil Penalty. (1) The cabinet shall assess a civil penalty in accordance with KRS 199.896(8) and KRS 199.990(4).

(2) A statement of deficiency shall be issued prior to, or concurrent with, the notice described in Section 4 of this administrative regulation.

(3) A statement of deficiency with a Type A violation shall be:

(a) Corrected within five (5) working days in accordance with 922 KAR 2:090, Section 9(3) and 9(8); and

(b) Subject to a civil penalty of no more than $1000 for each occurrence of a Type A violation.

(4) A statement of deficiency with a Type B violation shall:

(a) Have a written corrective action plan within ten (10) days in accordance with 922 KAR 2:090, Section 9(2) and 9(3); and

(b) Be subject to a civil penalty of $250 for each occurrence of a Type B violation.

(5) In accordance with KRS 199.896(8)(b)-(d), a licensee shall receive a monetary credit applied towards a civil penalty in the amount of:

(a) Fifty (50) dollars if a review of the licensee’s history finds no Type A or Type B violation cited during the three (3) years prior to the date of the statement of deficiency;

(b) Fifty (50) dollars if the written corrective action plan is:

1. Received by the cabinet within the timeframe specified for the violation type pursuant to subsection (3)(a) or (4)(a) of this section; and

2. Accepted by the cabinet; or

(c) Twenty-five (25) percent of the civil penalty if the licensee waives appeal rights described in Section 5 of this administrative regulation.

(6) Treble penalties shall be assessed pursuant to KRS 199.990(4).

Section 4. Civil Penalty Requirements. In addition to a violation of a requirement of the cabinet under the provisions of KRS 199.896, an offense subject to civil penalty shall include a violation of one (1) or more of the following regulatory requirements if the violation poses, at the time it occurs, an immediate threat to the health, safety, or welfare of a child served by a licensed child care facility:

(a) 922 KAR 2:090, Child care facility licensure;

(b) 922 KAR 2:110, Child care facility provider requirements; or

(c) 922 KAR 2:120, Child care facility health and safety standards.

(2) Notice that a civil penalty has been levied shall:

1. [a] Be hand delivered by cabinet staff or delivered by certified mail, return receipt requested, to the:

   (a) Licensee; or

   (b) Director of the child-care center or the director’s designee in accordance with 922 KAR 2:110; and

2. [b] Notice that a civil penalty has been levied shall:

   (a) Not exceed $1,000 for each occurrence;

   (b) Be made payable to the Kentucky State Treasurer; and

   (c) Be mailed to the Office of Inspector General;

   (d) That an appeal of a civil penalty shall not act to stay correction of a violation, pursuant to KRS 199.896(7);

   (e) That payment of a civil penalty shall be stayed if an appeal is requested; and

   (f) That the cabinet may:

   1. Deny, suspend, or revoke a license for the same offense for which a civil penalty is imposed; and

   2. Take other action in accordance with KRS 199.896(9)(d) The amount of the civil penalty shall be determined in accordance with KRS 199.896(9).

   (4) Treble penalties shall be assessed pursuant to KRS 199.990(4).

Section 5. Appeal Rights. (1) A licensee shall have appeal rights in accordance with KRS 199.990(4) and 922 KAR 2:090.

Section 13 governs the taking of an appeal by a licensed child care facility approved by a cabinet action adverse to the licensee’s interests.

(2) An appeal shall not limit the authority of the cabinet to:

(a) Issue an emergency order pursuant to KRS 13B.125(2); or

(b) Take action pursuant to KRS 199.896(9).

Section 6. Payment of Civil Penalty. (1) The cabinet shall deny an application for child-care center licensure or revoke a child-care center’s license if:

(a) Sixty (60) days have lapsed since the latter of either:

1. The notice in accordance with Section 4 of this administrative regulation; or

2. Completion of the administrative appeal process upholding the civil penalty; and
(b) A licensee fails to:
   1. Pay the civil penalty levied against the child-care center;
   2. Enter into an arrangement to pay a civil penalty that is approved by the cabinet; or
   3. Comply with the payment arrangement for the civil penalty.
(2) The cabinet may approve an amendment to a payment arrangement if:
   (a) A request for an amendment is received from the licensee; and
   (b) The cabinet makes a determination that the payment arrangement creates a hardship for the licensee or the child-care center’s operation with consideration given to:
      1. The individual circumstances of the licensee or child-care center; and
      2. Factors specified in KRS 199.896(8).
(3) The cabinet may terminate collection of a civil penalty if the:
   (a) Licensee dies;
   (b) Cabinet is unable to locate the licensee; or
   (c) Cabinet’s continued pursuit of the civil penalty would exceed:
      1. Amount of civil penalty; or
      2. Public benefit.
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office
(Amended After Comments)

907 KAR 3:170. Telehealth consultation coverage and reimbursement.


NECESSITY, FUNCTION, AND CONFORMITY: In accordance with KRS 194A.030(2), 194A.050(1), 205.520(3), 205.559(2), (7), 205.560

Section 1. Definitions. (1) “Advanced practice registered nurse” or “APRN”[practitioner or “APRN”] is defined by KRS 319.010(5).
(2) “Certified nutritionist” is defined by KRS 310.005.
(3) “Chiropractor” is defined by KRS 312.015(3).
(4) “Community mental health center” or “CMHC” means a facility that provides a comprehensive range of mental health services to Medicaid recipients of a designated area in accordance with KRS 210.370 to 210.485.
(5) “Dentist” is defined by KRS 319.010(19). “CPT code” means a code used for reporting procedures and services performed by physicians or other licensed medical professionals which is published annually by the American Medical Association in Current Procedural Terminology.
(6) “Department” means the Department for Medicaid Services or its designated agent.
(7) “Diabetes self-management training consultation” means the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care.
(8) “Direct physician contact” means that the billing practitioner chooses to do the same amount for a telehealth consultation as the department reimburses, but shall be authorized to reimburse as the department reimburses if the managed care organization chooses to do so.
(9) “Encounter” means one (1) visit by a recipient to a telehealth site where the recipient receives telehealth consultation in real time, during the visit, from a provider at a telehealth hub site.
(10) “Face-to-face” means: (a) In person; and (b) Not via telehealth.
(11) “Federal financial participation” is defined in 42 C.F.R. 410.203.
(12) “Health care provider” means a: (a) Currently enrolled Medicaid provider in accordance with 907 KAR 1:672; and (b) Currently participating Medicaid provider in accordance with 907 KAR 1:671.
(13) “Licensed physician” means an individual who is a: (a) Licensed physician; (b) Licensed advanced registered nurse practitioner; (c) Certified physician assistant working under physician supervision; (d) Licensed dentist or oral surgeon; (e) Community mental health center; (f) Psychologist with a license in accordance with KRS 319.010(5).
(14) “Hub site” means a telehealth site: (a) Where the telehealth provider performs telehealth; and (b) That is considered the place of service.
(15) “KentPAC means the Kentucky Patient Access and Care System.”
(16) “KentPAC PCCM means a Medicaid provider who is enrolled as a primary care case manager in the Kentuck Patient Access and Care System.”
(17) “Legally-authorized representative” means a Medicaid recipient's parent or guardian if a recipient is a minor child, or a person with power of attorney for a recipient.
(18) “Licensed clinical social worker” means an individual meeting the licensure requirements established in KRS 335.100.
(19) “Licensed dietitian” is defined by KRS 310.005(11).
(20) “Licensed marriage and family therapist” is defined by KRS 335.300(2).
(21) “Licensed professional clinical counselor” is defined by KRS 335.500(3).
(22) “Medical necessity” or “medically necessary” means a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
(23) “National Provider Identifier” or “NPI” means a standard unique health identifier for health care providers which: (a) Is required by 42 C.F.R. 455.440; and (b) Meets the requirements of 42 C.F.R. 162.406.
(24) “Optometrist” means an individual licensed to engage in the practice of optometry in accordance with KRS 230.210(2).
(25) “Physical therapist” is defined by KRS
“Physician” is defined by KRS 311.550(12).
“Physician assistant” is defined by KRS 311.840(3).
“Psychiatric medical resident” means an individual who:
(a) Possesses a special faculty license in accordance with KRS 311.550(29);
(b) Meets the qualification for licensure requirements established in KRS 311.571(1) or (2); and
(c) Is a resident as defined by 42 C.F.R. 415.152.
“Psychiatric registered nurse” means a registered nurse who:
(a) Has a master of science in nursing with a specialty in psychiatric or mental health nursing;
(b) Has a bachelor of science in nursing and at least one (1) year of experience in a mental health setting;
(c) Is a graduate of a three (3) year educational program and has at least two (2) years of experience in a mental health setting;
(d) Has an associate degree in nursing and at least three (3) years of experience in a mental health setting; or
(e) Has any level of education with American Nursing Association (ANA) certification as a psychiatric or mental health nurse.
“Psychologist” is defined by KRS 319.010(8).
“Registered nurse” is defined by KRS 314.801(5).
“Speech-language pathologist” is defined by KRS 334.420(1).
“Telehealth site” means a hub site where the recipient receiving the telehealth consultation is located.
“Telehealth consultation” is defined by KRS 205.510(15).
“Telehealth provider” means a:
(a) Currently enrolled Medicaid provider in accordance with 907 KAR 1.672;
(b) Currently participating Medicaid provider in accordance with 907 KAR 1.671; and
(c) Medicaid provider performing a telehealth consultation at a hub site.
“Telepresenter” means an individual operating telehealth equipment at a spoke site to enable a recipient to receive a telehealth consultation.
“Transmission cost” means the cost of the telephone line and related costs incurred during the time of the transmission of a telehealth consultation.
“Two (2) way interactive video” means a type of advanced telecommunications technology that permits a real time telehealth consultation to take place between a recipient and a telepresenter at the spoke site and a telehealth provider at the hub site.
Section 2. General Policies. (1) A telehealth consultation shall not be reimbursed by the department if:
(a) It is not medically necessary;
(b) The equivalent service is not covered by the department if provided in a face-to-face setting;
(c) It requires a face-to-face contact with a recipient in accordance with 42 C.F.R. 447.371;
(d) The provider of the telehealth consultation is:
1. Not currently enrolled in the Medicaid program pursuant to 907 KAR 1.672;
2. Not currently participating in the Medicaid program pursuant to 907 KAR 1.671;
3. Not in good standing with the Medicaid program;
4. Currently listed on the Kentucky DMS List of Excluded Providers; or
5. Currently listed on the United States Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities; or
(e) It is provided by a practitioner or provider not recognized or authorized by the department to provide the telehealth consultation or equivalent service in a face-to-face setting.
2. (a) A telehealth provider shall:
1. Be an approved member of the Kentucky Telehealth Network; and
2. (b) Comply with the standards and protocols established by the Kentucky Telehealth Board.
(b) To be an approved member of the Kentucky Telehealth Network, a provider shall:
1. Send a written request to the Kentucky Telehealth Board requesting membership in the Kentucky Telehealth Network; and
2. Be approved by the Kentucky Telehealth Board as a member of the Kentucky Telehealth Network.
(3) (a) A telehealth consultation referenced in Section 3 or 4 of this administrative regulation shall be provided to the same extent and with the same coverage policies and restrictions that apply to the equivalent service if provided in a face-to-face setting.
(b) If a telehealth coverage policy or restriction is not stated in this administrative regulation but is stated in another administrative regulation within Title 907 of the Kentucky Administrative Regu- lations, the coverage policy or restriction stated elsewhere within Title 907 of the Kentucky Administrative Regulations shall apply.
(4) A telehealth consultation shall be subject to utilization review for:
(a) Medical necessity;
(b) Compliance with this administrative regulation; and
(c) Compliance with applicable state or federal law.
(b) If the department determines that a telehealth consulta- tion is not medically necessary, is not compliant with this administrative regulation, or is not compliant with applicable state or federal law, the department shall not reimburse for the telehealth consultation.
(c) If the department determines that a telehealth consultation that has already reimbursed for was not medically necessary, was not compliant with this administrative regulation, or was not compliant with applicable state or federal law, the department shall recoup the reimbursement for the telehealth consultation from the provider.
(d) A telehealth consultation shall require:
(a) The use of two (2) way interactive video;
(b) A referral by a health care provider; and
(c) A referral by a recipient’s lock-in provider if the recipient is locked in pursuant to:
1. 42 C.F.R. 431.54; and
2. 907 KAR 1.677.
Section 3. Telehealth Consultation Coverage in a Setting That Is Not a Community Mental Health Center. (1) The policies in this section of this administrative regulation shall apply to a telehealth consultation provided in a setting that is not a community mental health center.
(2) The following telehealth consultations shall be covered by the department as follows:
(a) A physical health evaluation and management consultation provided by:
1. A physician;
2. An advanced practice registered nurse;
3. An optometrist; or
4. A chiropractor;
(b) A mental health evaluation and management service provided by:
1. A psychiatrist;
2. A physician in accordance with the limit established in 907 KAR 3.005;
3. An APRN in accordance with the limit established in 907 KAR 1.102;
4. A psychologist;
   a. With a license in accordance with KRS 319.010(5);
   b. With a doctorate degree in psychology;
   c. Who is directly employed by a psychiatrist; and
   d. If:
      i. The psychiatrist by whom the psychologist is directly em-
ployed also interacts with the recipient during the encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the psychologist is directly employed;
(b) Who is directly employed by a psychiatrist; and
(b) If:
(i) The psychiatrist by whom the licensed professional clinical
counselor is directly employed also interacts with the recipient
during the encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the licensed professional clinical counselor
is directly employed; or
(i) The psychiatrist by whom the licensed clinical social worker
is directly employed also interacts with the recipient during the
encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the licensed clinical social worker is directly
employed; or
7. A licensed marriage and family therapist:
(a) Who is directly employed by a psychiatrist; and
(b) If:
(i) The psychiatrist by whom the licensed marriage and family
therapist is directly employed also interacts with the recipient
during the encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the licensed marriage and family therapist
is directly employed; or
(c) Individual or group psychotherapy provided by:
1. A psychiatrist;
2. A physician in accordance with the limit established in 907
KAR 3:005;
3. An APRN in accordance with the limit established in 907
KAR 1:102;
4. A psychologist:
(a) With a license in accordance with KRS 319.010(5);
(b) With a doctorate degree in psychology;
(c) Who is directly employed by a psychiatrist; and
(d) If:
(i) The psychiatrist by whom the psychologist is directly em-
ploved also interacts with the recipient during the encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the psychologist is directly employed;
5. A licensed professional clinical counselor:
(a) Who is directly employed by a psychiatrist; and
(b) If:
(i) The psychiatrist by whom the licensed professional clinical
counselor is directly employed also interacts with the recipient
during the encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the licensed professional clinical counselor
is directly employed;
6. A licensed clinical social worker:
(a) Who is directly employed by a psychiatrist; and
(b) If:
(i) The psychiatrist by whom the licensed clinical social worker
is directly employed also interacts with the recipient during the
encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the licensed clinical social worker is directly
employed; or
7. A licensed marriage and family therapist:
(a) Who is directly employed by a psychiatrist; and
(b) If:
(i) The psychiatrist by whom the licensed marriage and family
therapist is directly employed also interacts with the recipient or
recipients during the encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the licensed marriage and family therapist
is directly employed;
(d) Pharmacologic management provided by:
1. A physician in accordance with the limit established in 907
KAR 3:005;
2. An APRN in accordance with the limit established in 907
KAR 1:102; or
3. A psychiatrist;
(e) A psychiatric, psychological, or mental health diagnostic
interview examination provided by:
1. A psychiatrist;
2. A physician in accordance with the limit established in 907
KAR 3:005;
3. An APRN in accordance with the limit established in 907
KAR 1:102;
4. A psychologist:
(a) With a license in accordance with KRS 319.010(5);
(b) With a doctorate degree in psychology;
(c) Who is directly employed by a psychiatrist; and
(d) If:
(i) The psychiatrist by whom the psychologist is directly em-
ploved also interacts with the recipient during the encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the psychologist is directly employed;
5. A licensed professional clinical counselor:
(a) Who is directly employed by a psychiatrist; and
(b) If:
(i) The psychiatrist by whom the licensed professional clinical
counselor is directly employed also interacts with the recipient
during the encounter; and
(ii) The telehealth consultation is billed under the NPI of the
psychiatrist by whom the licensed professional clinical counselor
is directly employed;
a. Physician;  
b. APRN directly employed by a physician;  
c. Physician assistant directly employed by a physician;  
2. Provided by a:  
a. Physician;  
b. APRN directly employed by a physician;  
c. Physician assistant directly employed by a physician;  
d. Registered nurse directly employed by a physician;  
e. Licensed dietitian directly employed by a physician, federally qualified health care center, rural health clinic, primary care center, a hospital’s outpatient department, or the Department for Public Health; and  
3. The telehealth consultation is billed under the:  
a. NPI of the physician, federally qualified health care center, rural health clinic, hospital’s outpatient department, or primary care center by whom the licensed dietitian is directly employed; or  
b. Department for Public Health if the certified nutritionist works for the Department for Public Health; 

h) An occupational therapy evaluation or treatment provided by an occupational therapist who is directly employed by a physician:  
1. If direct physician contact occurs during the evaluation;  
2. If the telehealth consultation is billed under the physician’s NPI; and  
3. In accordance with the limits established in 907 KAR 1:030;  

3. A psychologist:  
a. With a license in accordance with KRS 319.010(5);  
b. With a doctorate degree in psychology; and  
c. Who is directly employed by a physician or a psychiatrist:  
   i) In accordance with the limits established in 907 KAR 3:005;  
   ii) If the physician or psychiatrist by whom the psychologist is directly employed also interacts with the recipient during the encounter; and  
   iii) If the telehealth consultation is billed under the NPI of the physician or psychiatrist by whom the psychologist is directly employed; or  

u) End-stage renal disease monitoring, assessment, and consulting examinations for home dialysis recipients provided by:  
1. A physical therapist; or  
2. A doctor in accordance with the limits established in 907 KAR 1:030; or  
3. An APRN directly employed by a hospital’s outpatient department if the telehealth consultation is billed under the hospital’s outpatient department’s NPI; or  

Section 4. Telehealth Consultation Coverage in a Community Mental Health Center.  
1. The policies in this section of this administrative regulation shall apply to a telehealth consultation provided via a community mental health center,  
2. The limits, restrictions, exclusions, or policies:  
a. Which apply to a service provided face-to-face in a community mental health center shall apply to a telehealth consultation or service provided via telehealth via a community mental health center; and  

b. Established in 907 KAR 1:044 shall apply to a telehealth consultation or service provided via:  
1. Telehealth; and  
2. A community mental health center.  
3. The department shall not reimburse for a telehealth consultation provided via a community mental health center if:  
   a. The consultation is not billed under the community mental health center’s national provider identifier; or  
   b. The person who delivers the telehealth consultation is not:  
      i) Directly employed by the community mental health center; or  
      ii) An agent of a community mental health center.  
4. The following telehealth consultations provided via a community mental health center shall be covered by the department:  
   a. A psychiatric diagnostic interview examination provided:  
      i) In accordance with 907 KAR 1:044; and  
   b. A psychiatric diagnostic interview examination provided:  
      i) Is certified in the practice of psychiatric mental health nursing; and  
      ii) Meets the requirements established in 201 KAR 20:057; and  

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1. In accordance with 907 KAR 1:044; and
2. By:
   a. A psychiatrist; or
   b. A psychologist:
      (i) With a license in accordance with KRS 319.010(5); and
      (ii) With a doctorate in psychology; or
c. Pharmacologic management provided:
   1. In accordance with 907 KAR 1:044; and
   2. By:
      a. A physician; or
      b. A psychologist;
      c. An APRN who:
         (i) Is certified in the practice of psychiatric mental health nursing; and
         (ii) Meets the requirements established in 201 KAR 20:057;
      (d) Group psychotherapy provided:
         1. In accordance with 907 KAR 1:044; and
         2. By:
            a. A psychiatrist;
            b. A psychologist:
               (i) With a license in accordance with KRS 319.010(5); and
               (ii) With a doctorate degree in psychology;
            c. A licensed professional clinical counselor;
            d. A licensed marriage and family therapist;
            e. A licensed clinical social worker;
            f. A psychiatric registered nurse; or
            g. An APRN who:
               (i) Is certified in the practice of psychiatric mental health nursing; and
               (ii) Meets the requirements established in 201 KAR 20:057;
         (e) Mental health evaluation and management emergency services provided:
            1. In accordance with 907 KAR 1:044; and
            2. By:
               a. A psychiatrist;
               b. A psychologist:
                  (i) With a license in accordance with KRS 319.010(5); and
                  (ii) With a doctorate degree in psychology;
               c. A licensed professional clinical counselor;  
               d. A licensed marriage and family therapist;  
               e. A licensed clinical social worker;  
               f. A psychiatric medical resident;  
               g. A psychiatric registered nurse; or  
               h. An APRN who:
                  (i) Is certified in the practice of psychiatric mental health nursing; and
                  (ii) Meets the requirements established in 201 KAR 20:057;  
               or  
               (f) A mental health assessment provided:
                  1. In accordance with 907 KAR 1:044; and  
                  2. By a psychologist:
                     a. With a license in accordance with KRS 319.010(5); and  
                     b. With a doctorate degree in psychology;

Section 5 [Telehealth Coverage For Telehealth Not Provided in a Community Mental Health Center. (1) The department shall reimburse for the following telehealth consultations not provided via a community mental health center in accordance with the following provisions:
(a) Wound care with a CPT code of 97601 or 97602 provided by a physician or advanced registered nurse practitioner;
(b) A service, provided by a physician, chiropractor, or ARNP, which has an evaluation and management code of 99201 through 99215;
(c) A service, provided by a physician, chiropractor, or ARNP, with an evaluation and management code of 99241 through 99255;
(d) A psychiatric diagnosis or evaluation interview with a CPT code of 90801 through 90802 if provided by:
   1. A psychiatrist;
   2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   3. A psychologist with a license in accordance with KRS 319.010(5), and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   6. A physician; or
   7. An ARNP;
   (e) Outpatient individual psychotherapy with a CPT code of 90804 through 90809 if provided by:
      1. A psychiatrist;
      2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      6. A physician not to exceed four (4) encounters per recipient per year; or
      7. An ARNP not to exceed four (4) encounters per recipient per year;
   (f) Outpatient individual interactive psychotherapy with a CPT code of 90810 through 90815 if provided by:
      1. A psychiatrist;
      2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      6. A physician not to exceed four (4) encounters per recipient per year; or
      7. An ARNP not to exceed four (4) encounters per recipient per year;
   (g) Inpatient individual psychotherapy with a CPT code of 90816 through 90822 if provided by:
      1. A psychiatrist;
      2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      6. A physician not to exceed four (4) encounters per recipient per year; or
      7. An ARNP not to exceed four (4) encounters per recipient per year;
   (h) Inpatient individual interactive psychotherapy with a CPT code of 90823 through 90829 if provided by:
      1. A psychiatrist;
      2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
      6. A physician not to exceed four (4) encounters per recipient per year; or
      7. An ARNP not to exceed four (4) encounters per recipient per year;
chiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year.
(i) Other psychotherapy with a CPT code of 90845 through 90846 if provided by:
1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year.
(ii) Family therapy with a CPT code of 90847 if provided by:
1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year.
(iii) Group psychotherapy with a CPT code of 90849 through 90857 if provided by:
1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year.
(i) Psychiatric medication management with a CPT code of 90862 if provided by:
1. A psychiatrist;
2. A physician not to exceed four (4) encounters per recipient per year; or
3. An ARNP not to exceed four (4) encounters per recipient per year.
(ii) Interpretation of data to family or others with a CPT code of 90877 if provided by:
1. A psychiatrist;
2. A physician not to exceed four (4) encounters per recipient per year; or
3. An ARNP not to exceed four (4) encounters per recipient per year.
(iii) Physical therapy with a CPT code of 90887 if provided by:
1. A physical therapist;
2. A licensed physical therapist;
3. A licensed physical therapist with a doctorate degree in physical therapy;
4. A licensed physician assistant directly employed by a physical therapist;
5. A licensed physician assistant directly employed by a licensed physical therapist;
6. A licensed physician assistant directly employed by a licensed physician assistant;
7. A licensed physician assistant not to exceed four (4) encounters per recipient per year; or
8. An ARNP not to exceed four (4) encounters per recipient per year.
(iv) Speech therapy with a CPT code of 90888 if provided by:
1. A speech language pathologist;
2. A speech language pathologist with a doctorate degree in speech language pathology;
3. A speech language pathologist with an advanced degree in speech language pathology;
4. A speech language pathologist with a doctorate degree in speech language pathology;
5. A speech language pathologist not to exceed four (4) encounters per recipient per year; or
6. An ARNP not to exceed four (4) encounters per recipient per year.
(v) Occupational therapy with a CPT code of 90901 if provided by an occupational therapist;
(vi) Physical therapy with a CPT code of 90901 if provided by a physical therapist;
(vii) Individual medical nutrition therapy with an HCPCS code of G0308, G0309, G0311, G0314, G0315, G0317, or G0318 if provided by:
1. A dietitian;
2. A dietitian with a doctorate degree in nutrition;
3. Any other person or facility directly employed by a dietitian;
4. Any other person or facility directly employed by a dietitian not to exceed four (4) encounters per recipient per year; or
5. An ARNP not to exceed four (4) encounters per recipient per year.
(viii) Discharge of a patient from a nursing home with a CPT code of 90926 if provided by:
1. A physician;
2. A licensed practical nurse;
3. A licensed vocational nurse;
4. An ARNP;
5. A licensed vocational nurse not to exceed four (4) encounters per recipient per year; or
6. An ARNP not to exceed four (4) encounters per recipient per year.
(ix) Discharge of a patient from a nursing home with a CPT code of 90925 if provided by a physician;
(x) Physical therapy with a CPT code of 97001 if provided by a physical therapist;
(xi) Individual medical nutrition therapy with an HCPCS code of G0270 or a CPT code of 97802 through 97804 if provided by a licensed dietitian or certified nutritionist;
(xii) End stage renal disease services with an HCPCS code of G0308, G0309, G0311, G0314, G0315, G0317, or G0318 if provided by a physician or ARNP;
(xiii) Neurobehavioral status exam with a CPT code of 96116 if provided by:
1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year.
(xiv) Patient diabetes self-management education regarding diabetes care planning including nutrition, exercise, medication, or blood glucose testing equipment;
1. Provided by the physician, advanced registered nurse practitioner, or physician assistant who is managing the recipient's diabetic condition;
2. If provided by a registered nurse or dietitian; and
3. With a corresponding:
   a. HCPCS code of G0108 or G0109; or
   b. CPT code of 97802.
(xv) The department shall not reimburse for a telehealth consultation if the consultation:
1. Is not medically necessary; or
2. Requires a face-to-face contact with a recipient in accordance with 42 C.F.R. 447.271.
3. A telehealth consultation shall require:
Section 3. Coverage of Telehealth Provided by a Community Mental Health Center.

(1) The department shall reimburse for the following telehealth consultation provided via a community mental health center in accordance with the following provisions:

(a) A psychiatric diagnosis or evaluation interview with a CPT code of 90801 through 90802 if provided by:
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
   4. A licensed marriage and family therapist;
   5. A psychiatric medical resident;
   6. A psychiatric registered nurse;
   7. A psychiatric social worker; or
   8. An advanced registered nurse practitioner;

(b) Outpatient individual psychotherapy with a CPT code of 90803 through 90809 if provided by:
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
   4. A licensed marriage and family therapist;
   5. A licensed professional clinical counselor;
   6. A psychiatric medical resident;
   7. A psychiatric registered nurse;
   8. A licensed clinical social worker; or
   9. An advanced registered nurse practitioner;

(c) Inpatient individual psychotherapy
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
   4. A licensed marriage and family therapist;
   5. A licensed professional clinical counselor;
   6. A psychiatric medical resident;
   7. A psychiatric registered nurse;
   8. A licensed clinical social worker; or
   9. An advanced registered nurse practitioner;

(d) A referral by a recipient's KenPAC PCCM if the comparable service in accordance with 42 C.F.R. 447.371.

(e) A referral by a provider if the recipient is locked in pursuant to 42 C.F.R. 431.54 and 907 KAR 1:677.

(2) The department shall not reimburse for a telehealth consultation:

(a) Is not medically necessary; or

(b) Requires a face-to-face contact with a recipient in accordance with 42 C.F.R. 447.371.

(3) A telehealth consultation shall require:

(a) The use of two (2) way interactive video;

(b) A referral by a health care provider;

(c) A referral by a recipient's KenPAC PCCM if the comparable service in accordance with 42 C.F.R. 431.54 and 907 KAR 1:677.

Section 4. Reimbursement. (1)(a) The department shall reimburse a telehealth provider who is eligible for reimbursement from the department, is currently enrolled as a provider in the Medicaid program in accordance with 907 KAR 1:671 for a telehealth consultation:

1. [a] Except for a telehealth consultation provided by an APRN(ARNP) or CMHC, an amount equal to the amount paid for a comparable in-person service in accordance with 907 KAR 3:010;

2. [b] If a CMHC, in accordance with 907 KAR 1:045; or

3. [c] If provided by an APRN(ARNP), an amount equal to the amount paid for a comparable in-person service in accordance with 907 KAR 1:104.

(b1). Reimbursement for a telehealth consultation pro-
vided by a practitioner who is employed by a provider or is an agent of a provider shall be a matter between the provider and the practitioner.

2. The department shall not be liable for reimbursing a practitioner who is employed by a provider or is an agent of a provider.

(c) A managed care organization shall not be required to reimburse the same amount for a telehealth consultation as the department reimburses, but shall be authorized to reimburse the same amount as the department reimburses if the managed care organization chooses to do so.

(2) A telehealth provider shall bill for a telehealth consultation using the appropriate evaluation and management CPT or HCPCS code as specified in Section 2 or 3 of this administrative regulation along with the corresponding [two (2) letter “GT” modifier.

(3) The department shall not require the presence of a health care provider requesting a telehealth consultation at the time of the telehealth consultation unless it is requested by a telehealth provider at the hub site.

(4) The department shall not reimburse for transmission costs.

Section 6.[6] Confidentiality and Data Integrity. (1) A telehealth consultation shall be performed on a secure telecommunications line or utilize a method of encryption adequate to protect the confidentiality and integrity of the telehealth consultation information.

(2) Both a hub site and a spoke site shall use authentication and identification to ensure the confidentiality of a telehealth consultation.

(3) A provider of a telehealth consultation shall implement confidentiality protocols that include:

(a) Identifying personnel who have access to a telehealth consultation;

(b) Usage of unique passwords or identifiers for each employee or person with access to a telehealth transmission; and

(c) Preventing unauthorized access to a telehealth transmission.

(4) A provider’s protocols and guidelines shall be available for inspection by the department upon request.

Section 7.[6] Informed Consent. (1) Before providing a telehealth consultation to a recipient, a health care provider shall document written informed consent from the recipient and shall ensure that the following written information is provided to the recipient in a format and manner that the recipient is able to understand:

(a) The recipient shall have the option to refuse the telehealth consultation at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of a Medicaid benefit to which the recipient is entitled;

(b) The recipient shall be informed of alternatives to the telehealth consultation that are available to the recipient;

(c) The recipient shall have access to medical information resulting from the telehealth consultation as provided by law;

(d) The dissemination, storage, or retention of an identifiable recipient image or other information from the telehealth consultation shall comply with 42 U.S.C. 1301 et seq., 45 C.F.R. Parts 160, 162, 164, KRS 205.566, 216.2927, and any other federal law or regulation or state law establishing individual health care data confidentiality policies [provisions];

(e) The recipient shall have the right to be informed of the parties who will be present at the spoke site and the hub site during the telehealth consultation and shall have the right to exclude any one from either site; and

(f) The recipient shall have the right to object to the video taping of a telehealth consultation.

(2) A copy of the signed informed consent shall be retained in the recipient’s medical record and provided to the recipient or the recipient’s legally-authorized representative upon request.

(3) The requirement to obtain informed consent before providing a telehealth consultation shall not apply to an emergency situation if the recipient is unable to provide informed consent and the recipient’s legally-authorized representative is unavailable.

Section 8.[2] Medical Records. (1) A request for a telehealth consultation from a health care provider and the medical necessity for the telehealth consultation shall be documented in the recipient’s medical record.

(2) A health care provider shall keep a complete medical record of a telehealth consultation provided to a recipient and follow applicable state and federal statutes and regulations for medical recordkeeping and confidentiality in accordance with KRS 194A.060, 422.317, 434.840 - 434.860, 42 C.F.R. 431.300 to 431.307, and 45 C.F.R. 164.530(i).

(b) A health care provider shall have the capability of generating a hard copy of a medical record of a telehealth consultation.

(4) Documentation of a telehealth consultation by the referring health care provider shall be included in the recipient’s medical record and shall include:

(a) The diagnosis and treatment plan resulting from the telehealth consultation and a progress note by the referring health care provider if present at the spoke site during the telehealth consultation;

(b) The location of the hub site and spoke site;

(c) A copy of the signed informed consent form; [aud]

(d) Documentation supporting the medical necessity of the telehealth consultation within thirty (30) days of the consultation to the referring health care provider.

(e) The referral order and complete information from the referring health care provider who requested the telehealth consultation for the recipient.

(5)(a) A telehealth provider’s diagnosis and recommendations resulting from a telehealth consultation shall be documented in the recipient’s medical record at the office of the health care provider who requested the telehealth consultation.

(b) Except as established in paragraph (c) of this subsection, a telehealth provider shall send a written report regarding a telehealth consultation within thirty (30) days of the consultation to the referring health care provider.

(c) If a community mental health center was the referring health care provider and the provider of the telehealth consultation for a recipient, the requirement in paragraph (b) of this subsection shall not apply.

Section 9.[8] Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies federal financial participation for the policy; or

(2) Disapproves the policy [provision established in this administrative regulation shall be effective contingent upon the department’s receipt of federal financial participation for the respective provision].

Section 10.[9] Appeal Rights. (1) An appeal of a department determination regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department determination regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) A provider may appeal a department-written determination as to the application of this administrative regulation in accordance with 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HANES, Secretary
APPROVED BY AGENCY: January 14, 2013
FILED WITH LRC: January 14, 2013 at 4 p.m.
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administra-
tive regulation establishes Department for Medicaid Services (DMS) policies relating to telehealth. The coverage policies in this administrative regulation shall apply to a managed care organization’s (MCO’s) coverage of Medicaid services for individuals enrolled in the MCO for the purpose of delivering Medical or Kentucky Children’s Health Insurance Program services. An MCO shall not be required to reimburse pursuant to this administrative regulation, but shall be authorized to do so if it chooses.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS policies relating to telehealth in accordance with KRS 194A.125 and KRS 205.559.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing DMS telehealth policies.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing DMS telehealth policies.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment makes the administrative regulation consistent with policies approved by the Centers for Medicare and Medicaid Services (CMS) in order to ensure federal funding for the policies. The amendment includes the telehealth services and clarifying provider and practitioner types authorized to perform telehealth services. The amendment clarifies that Telehealth practitioners in the community mental health center (CMHC) realm may be agents of a CMHC rather than directly employed by the CMHC; clarifies the process of becoming a member of the Kentucky Telehealth Network; clarifies that DMS will reimburse or may choose not to reimburse for a Telehealth consultation if it is not medically necessary or does not comply with applicable state or federal law; authorizes individual medical nutrition therapy and diabetes self-management Telehealth consultations in hospital outpatient department’s; authorizes occupational therapy, physical therapy, and speech therapy Telehealth consultations for nursing facility resident and clarifies that occupational therapists, physical therapists, and speech language pathologists can be agents (in addition to employees) of certain providers; clarifies that Telehealth practitioners in community mental health centers may be agents (in addition to employees) of community mental health centers; authorizes group psychotherapy, mental health evaluation and management emergency services, and mental health assessments as Telehealth consultations in community mental health centers; clarifies that managed care organizations are not required to reimburse the same fee amount as DMS does for Telehealth consultations; clarifies that providers must be able to generate a copy of a medical record; and correct a couple of typographical errors.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to ensure that policies stated in the administrative regulation are consistent with policies approved by CMS (for federal funding.) The amendment after comments is necessary to clarify policy; to authorize additional Telehealth consultations which are authorized by the Centers for Medicare and Medicaid Services; and to enhance recipient access to care.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by clarifying policy and enhancing recipient access to care within the parameters approved by the Centers for Medicare and Medicaid Services.

(d) How the amendment will assist in the effective administration of this statute: The amendment will assist in the effective administration of the authorizing statutes by conforming the administrative regulation’s policies to those approved by CMS; thus, ensuring federal funding for the policies. The amendment after comments conforms to the content of the authorizing statutes by clarifying policy and enhancing recipient access to care within the parameters approved by the Centers for Medicare and Medicaid Services.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are fifty-nine (59) telehealth sites in the Kentucky telehealth network. The provider network is primarily comprised of hospitals/medical centers but also includes health departments and physicians’ offices among others.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation or amendment: To be reimbursed for a telehealth consultation, a provider will have to comply with the policies and requirements established in this administrative regulation. Participation is optional, not mandatory.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS anticipates that the amendment will be budget neutral. For information purposes, in state fiscal year (SFY) 2011 (July 1, 2010 through June 30, 2011), DMS paid $345,221.13 in claims for services provided via telehealth. In SFY 2012 DMS’s payment for claims dropped as expected due to the implementation of managed care. In SFY SFY DMS paid $149,190.18 in claims for services provided via telehealth. For the period spanning November 1, 2011 through June 30, 2012 (DMS implemented managed care on November 1, 2011), DMS’s managed care organizations paid $170,547.65 in claims for services provided via telehealth.

(b) On a continuing basis: DMS anticipates that the amendment will be budget neutral.

(FISCAL NOTE ON STATE OR LOCAL GOVERNMENT)

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be impacted by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by KRS 194A.010, 194A.030(2), 194A.125, 205.520, 205.559.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for
(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates that the amendment will be budget neutral. For information purposes, in state fiscal year (SFY) 2011 (July 1, 2010 through June 30, 2011), DMS paid $345,221.13 in claims for services provided via telehealth. In SFY 2012 DMS’s payment for claims dropped as expected due to the implementation of managed care. In SFY DMS paid $149,190.18 in claims for services provided via telehealth. For the period spanning November 1, 2011 through June 30, 2012 (DMS implemented managed care on November 1, 2011), DMS’s managed care organizations paid $170,547.65 in claims for services provided via telehealth.

(d) How much will it cost to administer this program for subsequent years? DMS expects that the amendment will be budget neutral.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:
VOLUME 39, NUMBER 8 – FEBRUARY 1, 2013
PROPOSED AMENDMENTS

KENTUCKY HIGHER EDUCATION ASSISTANCE AUTHORITY
Division of Student and Administrative Services
(Amendment)

11 KAR 4:080. Student aid applications.


NECESSITY, FUNCTION, AND CONFORMITY: KRS 164.748(4) authorizes the Authority to promulgate administrative regulations pertaining to the awarding of grants, scholarships, and honorary scholarships as provided in KRS 164.740 to 164.7891. This administrative regulation designates and incorporates the applications to be utilized under the grant, scholarship, and work-study programs administered by KHEAA.

Section 1. Applications. In order to participate in a specified grant, scholarship, or work-study program administered by the Kentucky Higher Education Assistance Authority, the following application forms shall be completed in accordance with their instructions:

(a) For the KHEAA Grant Program as set forth in 11 KAR 5:130, the 2013-2014[2012-2013] Free Application for Federal Student Aid (FAFSA);
(b) For the KHEAA Work-Study Program as set forth in 11 KAR 6:010, the KHEAA Work-Study Program Student Application;
(c) For the Teacher Scholarship Program as set forth in 11 KAR 8:030, the Teacher Scholarship Application;
(d) For the Early Childhood Development Scholarship Program as set forth in 11 KAR 16:010:
   (a) The 2013-2014[2012-2013] Free Application for Federal Student Aid (FAFSA);
   (b) The Early Childhood Development Scholarship Application;
   (c) For the Robert C. Byrd Honors Scholarship Program as set forth in 11 KAR 18:010:
      (a) For high school and home school students, the Robert C. Byrd Honors Scholarship Program;
      (b) For GED recipients, the Robert C. Byrd Honors Scholarship Program GED Recipients;
   (d) For the Go Higher Grant Program as set forth in 11 KAR 5:200;
   (e) The 2013-2014[2012-2013] Free Application for Federal Student Aid (FAFSA); and
   (f) The Go Higher Grant Program Application;
   (g) For the Coal County Scholarship Program for Pharmacy Students as set forth in 11 KAR 19:010, the Coal County Scholarship Program for Pharmacy Students Application.

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:
   (b) The "KHEAA Work-Study Program Student Application", July 2001;
   (c) The "Teacher Scholarship Application", June 2006;
   (d) The "Early Childhood Development Scholarship Application", April 2006;
   (e) The "Robert C. Byrd Honors Scholarship Program", June 2009;
   (f) The "Robert C. Byrd Honors Scholarship Program GED Recipients", June 2009;
   (g) The "Go Higher Grant Program Application", January 2008; and
   (h) The "Coal County Scholarship Program for Pharmacy Students Application", February 2011.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Higher Education Assistance Authority, 100 Airport Road, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. The material may also be obtained at www.kheaa.com.

KRISTI P. NELSON, Chair
APPROVED BY AGENCY: December 11, 2012
FILED WITH LRC: January 11, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Monday, February 25, 2013 at 10:00 a.m. Eastern Time at 100 Airport Road, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by 5 workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until close of business on February 28, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Diana L. Barber, General Counsel, Kentucky Higher Education Assistance Authority, P.O. Box 798, Frankfort, Kentucky 40602-0798, phone (502) 696-7298, fax (502) 696-7293.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Rebecca Gilpatrick
(1) Provide a brief summary of:
   (a) What this administrative regulation does: This administrative regulation designates and incorporates the applications to be utilized under the grant, scholarship, and work-study program administered by the Authority.
   (b) The necessity of this administrative regulation: The Authority is required to promulgate administrative regulations pertaining to the administration of the Early Childhood Development Scholarship Program, KHEAA Work-study Program, Teacher Scholarship Program, College Access Program (CAP), Kentucky Tuition Grant (KTG), and Go Higher Grant Programs as well as the Robert C. Byrd Scholarship Program pursuant to KRS 164.518(3), 164.746(6), 164.748(4), 164.753(3), (6), 164.7535, 164.769(5), (6)(f), 34 C.F.R. 654.30, 654.41, and 20 U.S.C. 1070d-37, 1070d-38.
   (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by prescribing the applications to be utilized under the grant, scholarship and work-study programs administered by the Authority.
   (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by prescribing and incorporating the various application forms to be used by students to apply for the financial aid programs administered by the Authority.
   (e) How this amendment to an existing administrative regulation will change this existing administrative regulation: The amendment changes the existing regulation by specifying the latest version of the Free Application for Federal Student Aid (FAFSA) for the 2013-2014 academic year that is to be completed by applicants for participation in the student aid programs administered by the Authority.
   (f) The necessity of this amendment to this administrative regulation: The amendment to this administrative regulation is necessary in order to require student recipients to complete the
most recent version of the FAFSA.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. The administrative regulation will result in no additional expenditures by or revenues to the Authority during the first full year of its effectiveness.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation will not generate any revenue.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will not generate any revenue.

(c) How much will it cost to administer this program for the first year? No costs are associated with this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? No costs are associated with this administrative regulation.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

FINANCE AND ADMINISTRATION CABINET
Kentucky Teachers’ Retirement System
(Amendment)

102 KAR 1:230. Limitations on benefits.


STATUTORY AUTHORITY: KRS 161.310 (1), 161.716.

NECESSITY, FUNCTION AND CONFORMITY: KRS 161.310(1) requires the board of trustees to promulgate administrative regulations for the administration of the funds of the retirement system and for the transaction of business. KRS 161.716 requires the board of trustees to promulgate administrative regulations as are necessary to remove any conflicts with federal laws and to protect the interests of the members and survivors of members of the retirement system. This administrative regulation establishes the limitations on benefits required by 26 U.S.C. 415.

Section 1. Definitions. (1) “415(b) limit” means the limitation on benefits established by 26 U.S.C. 415(b).

(2) “415(c) limit” means the limitation on annual additions established by 26 U.S.C. 415(c).

(3) “Annual benefit” means, for purposes of the 415(b) limit, a benefit payable annually in the form of a straight life annuity (without ancillary benefits) without regard to the benefit attributable to after-tax employee contributions (except pursuant to 26 U.S.C. 415(n) and to rollover contributions (as defined in 26 U.S.C. 415(b)(2)(A)). The “benefit attributable” is determined in accordance with 26 C.F.R. 1.415(b).

(4) “Defined dollar benefit limitation” means $160,000, as adjusted, effective January 1 each year, in the manner established by the Secretary of the United States Treasury pursuant to 26 U.S.C. 415(d) and payable in the form of a straight life annuity. A limitation as adjusted under 26 U.S.C. 415(d) applies to limitation years for which the adjustment applies.

(5) “Limitation year” means the calendar year.

(6) “Nonqualified service credit” means, effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, permissive service credit other than that allowed with respect to:

(a) Service as an employee of the Government of the United States or any state, agency, or political subdivision thereof (other than military service or service for credit that was obtained as a result of a repayment described in 26 U.S.C. 415(k)(3));

(b) Service as an employee, other than as an employee de-
scribed in paragraph (a) of this subsection, of an education organization described in 26 U.S.C. 170(b)(1)(A)(ii) that is a public, private, or sectarian school that provides elementary education or secondary education through grade twelve (12), or a comparable level of education as determined pursuant to the applicable law of the jurisdiction in which the service was performed;

(c) Service as an employee of an association of employees described in paragraph (a) of this subsection; or

(d) Military service, other than qualified military service pursuant to 26 U.S.C. 414(u), recognized by the retirement system.

Section 2. Adjustments and Limitations. (1) If the member has fewer than ten (10) years participation in the plan, the defined benefit dollar limitation shall be multiplied by a fraction.

(a) The numerator shall be the number of years (or part thereof) of participation in the plan, and the denominator shall be ten (10).

(b) The reduction established in this subsection shall not apply to preretirement death and disability benefits.

(2) If the benefit of a member begins prior to age sixty-two (62), and because the plan provides an immediately commencing straight life annuity payable both at age sixty-two (62) and the age of benefit commencement, the defined benefit dollar limitation shall be applicable to the participant at the earlier age shall be an annual benefit payable in the form of a straight life annuity, beginning at the age of benefit commencement.

(a) The actuarial equivalent of the defined benefit dollar limitation applicable to the member at age sixty-two (62) (adjusted pursuant to subsection (1) of this section, if required) shall be the lesser of (a) or (b):

(a) The actuarial equivalent (at the earlier age) adjusted pursuant to subsection (1) of this section if necessary, with actuarial equivalence computed using a five percent interest rate and the applicable mortality table for the annuity starting date as specified by the system actuary (and expressing the member's age in completed calendar months as of the annuity starting date); and

(b) The actuarial equivalent (at the earlier age) of the defined benefit dollar limitation adjusted pursuant to subsection (1) of this section if necessary, with actuarial equivalence computed using a five percent interest rate and the applicable mortality table specified by the system actuary.

(3) The reductions provided for in this subsection shall not apply to preretirement disability benefits or preretirement death benefits.

(4) If the benefit of a member begins after the member attains age sixty-five (65), and because the plan provides an immediately commencing straight life annuity payable both at age sixty-five (65) and the age of benefit commencement, the defined benefit dollar limitation shall be the lesser of the following (a) or (b):

(a) Applicable to the member at the later age shall be the annual benefit payable in the form of a straight life annuity, beginning at the later age, that shall be actuarially equivalent to the defined benefit dollar limitation applicable to the participant at age sixty-five (65) (adjusted pursuant to subsection (1) of this section, if required). The actuarial equivalent of the defined benefit dollar limitation applicable at an age after sixty-five (65) shall be determined as follows:

(a) The lesser of the actuarial equivalent (at the later age) of the defined benefit dollar limitation computed using the interest rate and mortality table specified by the system actuary, and

(b) The actuarial equivalent (at the later age) of the defined benefit dollar limitation (adjusted under subsection (1) of this section if necessary), with actuarial equivalence computed using a five percent interest rate assumption and the mortality table specified by the system actuary (and expressing the member's age based on completed calendar months as of the annuity starting date). For these purposes, mortality between age sixty-five (65) and the age at which benefits commence shall be ignored.

(b) The defined benefit dollar limitation (adjusted under subsection (1) of this section if necessary), multiplied by the ratio of the annual amount of the adjusted immediately commencing straight life annuity under the plan at the member's annuity starting date to the annual amount of the adjusted immediately commencing straight life annuity under the plan at age sixty-five (65), both determined without applying the 415(b) limit. For this purpose, the adjusted immediately commencing straight life annuity under the plan at the plan member's annuity starting date is the annual amount of such annuity payable to the member, computed disregarding the member's accruals after age sixty-five (65) but including actuarial adjustments even if those actuarial adjustments are used to offset accruals, and the adjusted immediately commencing straight life annuity under the plan at age sixty-five (65) is the annual amount of such annuity that would be payable under the plan to a hypothetical member who is age sixty-five (65) and has the same accrued benefit as the member.

(5) If the benefit under the retirement system is other than the form specified in Section 2.2.1 of this administrative regulation, then the benefit shall be adjusted so that it is the equivalent of the annual benefit, using factors established in 26 C.F.R. 1.415(b).

(6) If the form of benefit without regard to the automatic benefit increase feature is not a straight life annuity or a qualified joint and survivor annuity, then subsection (5) of this section shall be applied by either reducing the section 415(b) limit applicable at the annuity starting date in the form of benefit to an actuarially equivalent amount determined using the assumptions established in 26 C.F.R. 1.415(b)(1)(c)(2)(ii) that takes into account the additional benefits under the form of benefit as follows:

(a) For a benefit paid in a form to which 26 U.S.C. 417(e)(3) does not apply, a monthly benefit, the actuarially equivalent straight life annuity benefit that is the greater of (or the reduced 415(b) limit applicable at the annuity starting date that is the "lesser of") if adjusted in accordance with the following assumptions:

1. The annual amount of the straight life annuity (if any) payable to the member under the retirement system commencing at the same annuity starting date as the form of benefit to the member;

2. The annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the form of benefit payable to the member, computed using a five percent interest rate assumption (or the applicable statutory interest assumption) and:

a. For limitation years prior to January 1, 2009, the applicable mortality tables described in 26 C.F.R. 1.417(e)(1-1)(d); and

b. For limitation years after December 31, 2008, the applicable mortality tables described in 26 U.S.C. 417(e)(3)(B).

(7) Effective on and after January 1, 2009, for purposes of applying the 415(b) limit to a member, the following shall apply:

(a) A member's applicable 415(b) limit shall be applied to the member's annual benefit in the member's first limitation year without regard to any automatic cost of living adjustments; and

(b) To the extent that the member's annual benefit equals or exceeds the 415(b) limit, the member shall no longer be eligible for cost of living increases until the benefit plus the accumulated increases is less than the 415(b) limit.

2. In any subsequent limitation year, a member's annual benefit, including any automatic cost of living increases, shall be tested under the then applicable 415(b) limit including any adjustment to the 26 U.S.C. 415(b)(1)(A) dollar limit pursuant to 26 U.S.C. 415(d) and 26 C.F.R. 1.415(b).

Section 3. Participation in Other Qualified Plans: Aggregation of Limits. (1) The 415(b) limit with respect to any member who at any time has been a member in any other defined benefit plan as defined in 26 U.S.C. 414(j) maintained by the member's employer in a retirement system shall apply as if the total benefits payable under all these defined benefit plans in which the member has
been a member were payable from one (1) plan.

(2) The 415(c) limit with respect to any member who at any time has been a member in any other defined contribution plan as defined in 26 U.S.C. 414(i) maintained by the member's employer in a retirement system shall apply as if the total annual additions under all these defined contribution plans in which the member has been a member were payable from one (1) plan.

Section 4. Effect on Members. (1) Benefit increases resulting from the increase in the limitations of 26 U.S.C. 415(b) shall be provided to all current and former members, with benefits limited by 26 U.S.C. 415(b), who have an accrued benefit under the plan immediately prior to the effective date.

(2) These benefit increases shall not be provided to current and former members who have an accrued benefit resulting from a benefit increase solely as a result of the increases in limitations under 26 U.S.C. 415(b).

Section 5. Benefits Not Taken into Account for 415(b) Limit. The following benefits shall not be taken into account in applying these limits:

(1) Any ancillary benefit that is not directly related to retirement income benefits; and

(2) That portion of any joint and survivor annuity that constitutes a qualified joint and survivor annuity.

Section 6. 415(c) Limit. Except as provided in Section 7 of this administrative regulation, after-tax member contributions or other annual additions with respect to a member shall not exceed the lesser of $40,000 (as adjusted pursuant to 26 U.S.C. 415(d)) or 100 percent of the member's compensation.

(1) Annual additions shall be defined to mean the sum (for any year) of employer contributions to a defined contribution plan, post-tax member contributions, and forfeitures credited to a member's individual account.

(b) Member contributions shall be determined without regard to rollover contributions and to picked-up employee contributions that are paid to a defined benefit plan.

(2) For purposes of applying the 415(c) limits only, the definition of compensation, if applicable, shall be compensation actually paid or made available during a limitation year, except as noted below and as permitted by 26 C.F.R. 1.415(c)-2, except, that member contributions picked up under 26 U.S.C. 414(h), shall not be treated as compensation.

(3) Unless another description of compensation that is permitted by 26 C.F.R. 1.415(c)-2 is specified by a retirement system, compensation shall be described as wages within the meaning of 26 U.S.C. 415(a) and all other payments of compensation to an employee by an employer for which the employer is required to furnish the employee a written statement pursuant to 26 U.S.C. 6041(d), 6051(a)(3) and 6052 and shall be determined without regard to any rules under 26 U.S.C. 3401(a) that limit the remuneration included in wages based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in 26 U.S.C. 3401(a)(2)).

(a)(i) For limitation years beginning on and after January 1, 1998, compensation shall also include amounts that would otherwise be included in compensation but for an election under 26 U.S.C. 125(a), 402(e)(3), 402(h)(1)(B), 402(k), or 457(b).

2. For limitation years beginning on and after January 1, 2001, compensation shall also include any elective amounts that are not includable in the gross income of the employee by reason of 26 U.S.C. 132(f)(4).

(b) For limitation years beginning on and after January 1, 2009, compensation for the limitation year shall also include compensation paid by the later of two and one-half (2 1/2) months after an employee's severance from employment or the end of the limitation year that includes the date of the employee's severance from employment if:

1. The payment is:
   a. Regular compensation for services during the employee's regular working hours;
   b. Compensation for services outside the employee's regular working hours, such as overtime or shift differential; or
   c. Commissions, bonuses, or other similar payments; and

2. Absent a severance from employment, the payments would have been paid to the employee while the employee continued in employment with unused accrued bona fide sick, vacation, or other leave and that the employee would have been able to use if employment had continued.

(c) Back pay, within the meaning of 26 C.F.R. 1.415(c)-2(g)(8), shall be treated as compensation for the limitation year to which the back pay relates to the extent the back pay represents wages and compensation that would otherwise be included pursuant to this description.

(d) If the annual additions for any member for a plan year exceed the limitation under 26 U.S.C. 415(c), the Internal Revenue Code, the excess annual addition shall be corrected as permitted under the Employee Plans Compliance Resolution System (or similar IRS correction program).

Section 7. Service Purchases under Section 415(n). (1) Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, if a member makes one (1) or more contributions to purchase permissive service credit under a retirement system, then the requirements of 26 U.S.C. 415(n) shall be treated as met only if:

(a) The requirements of 26 U.S.C. 415(b) are met, determined by treating the accrued benefit derived from all these contributions as annual additions for purposes of the 415(b) limit; or

(b) The requirements of 26 U.S.C. 415(c) are met, determined by treating all these contributions as annual additions for purposes of the 415(c) limit.

(2) For purposes of applying this section, a retirement system shall not fail to meet the reduced limit under 26 U.S.C. 415(b)(2)(C) solely by reason of this section and shall not fail to meet the percentage limitation pursuant to 26 U.S.C. 415(c)(1)(B) solely by reason of this section.

(3)(a) Permissive service credit shall consist of service credit:

1. Recognized by a retirement system for purposes of calculating a member's benefit under a retirement system;

2. The member has not received under a retirement system; and

3. That the member may receive only by making a voluntary additional contribution, in an amount determined under a retirement system, which does not exceed the amount necessary to fund the benefit attributable to the service credit.

(b) Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, the term may include service credit for periods for which there is no performance of service, and, notwithstanding paragraph (a)(2) of this subsection, may include service credited in order to provide an increased benefit for service credit that a member is receiving under a retirement system.

(4) The retirement system shall fail to meet the requirements of this section if:

(a) More than five (5) years of nonqualified service credit are taken into account for purposes of this subparagraph; or

(b) Any nonqualified service credit is taken into account pursuant to this section before the member has at least five (5) years of participation under a retirement system.

(5) In the case of service described in Section 1(7)(a), (b), or (c) of this administrative regulation, the service shall be nonqualified service if recognition of the service would cause a member to receive a retirement benefit for the same service under more than one (1) plan.

(6) In the case of a trustee-to-trustee transfer after December 31, 2001, to which 26 U.S.C. 403(b)(13)(A) or 26 U.S.C. 457(e)(17)(A) applies, without regard to whether the transfer is made between plans maintained by the same employer:

(a) The limitations of subsection (4) of this section shall not apply in determining whether the transfer is for the purchase of permissive service credit; and

(b) The distribution rules applicable under federal law to a retirement system shall apply to these amounts and any benefits attributable to these amounts.

(7)(a) For an eligible member, the 415(c) limit shall not be applied to reduce the amount of permissive service credit that may be
purchased to an amount less than the amount that was allowed to be purchased under the terms of the retirement system as in effect on August 5, 1997.

(b) For purposes of this subsection, an eligible member shall be an individual who first became a member in the retirement system before January 1, 1998.

Section 8. Modification of Contributions for 415(c) and 415(n) Purposes. The retirement system may modify a request by a member to make a contribution to a retirement system if the amount of the contribution would exceed the limits provided in 26 U.S.C. 415 by using the following methods:

(1) If the law requires a lump sum payment for the purchase of service credit, the retirement system may establish a periodic payment plan for the member to avoid a contribution in excess of the limits established in 26 U.S.C. 415(c) or 415(n).

(2) If payment pursuant to section (1) of this subsection shall not avoid a contribution in excess of the limits established in 26 U.S.C. 415(c) or 415(n), the retirement system may either reduce the member's contribution to an amount within the limits of those sections or refuse the member's contribution.

Section 9. Repayments of Cashouts. Any repayment of contributions, including interest thereon, to the retirement system with respect to an amount previously refunded upon a forfeiture of service credit under a retirement system or another governmental plan maintained by the Commonwealth or a local government within the Commonwealth shall not be taken into account for purposes of the 415(b) or (c) limits.

DR. TOM SHELTON, Chairperson
APPROVED BY AGENCY: December 17, 2012
FILED WITH LRCS: January 14, 2013 at noon
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2013, at 9:00 a.m. at the Kentucky Teachers’ Retirement System, 479 Versailles Road, Frankfort, Kentucky. Individuals interested in being heard at this hearing shall notify this agency in writing by February 14, 2013, five (5) working days prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by this date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given the opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation through February 21, 2013. Any written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Robert B. Barnes, Deputy Executive Secretary of Operations and General Counsel, Kentucky Teachers’ Retirement System, 479 Versailles Road, Frankfort, Kentucky 40601, phone (502) 848-8500, fax (502) 573-0199.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT
Contact Person: Robert B. Barnes
(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes Kentucky Teachers’ Retirement System’s compliance with specified provisions of the Internal Revenue Code regarding the limitation of benefits.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to ensure compliance with specified provisions of the Internal Revenue Code regarding limitation of benefits.
(c) How this administrative regulation conforms to the content of the authorizing statute: This administrative regulation conforms to the content of the authorizing statute by ensuring compliance with federal laws and proper administration of the retirement system’s qualified defined benefit plan.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the statutes by ensuring compliance with applicable federal law.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment provides specific language required for calculating the benefit limits required by 26 U.S.C. 415(b).
(b) The necessity of the amendment to this administrative regulation: To provide specific language for calculating the benefit limits required by 26 U.S.C. 415(b) and as requested by the Internal Revenue Service to ensure the retirement system’s continued qualification under 26 U.S.C. 401(a).
(c) How the amendment conforms to the content of the authorizing statute: This amendment conforms to the content of the authorizing statute by ensuring compliance with federal laws and proper administration of the retirement system’s qualified defined benefit plan.
(d) How the amendment will assist in the effective administration of the statutes: This amendment conforms to the content of the authorizing statute by ensuring compliance with federal law by providing the method of calculation of the benefit limits required by 26 U.S.C. 415(b).
(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation applies to members of the retirement system whose benefits would exceed the limit of 26 U.S.C. 415(b) and whose number has never exceeded single digits.
(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to comply with this administrative regulation or amendment: No actions are required.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There is no cost.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): These members’ accounts will remain in compliance with the Internal Revenue Code and thereby avoid potential penalties and additional taxation.
(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: There is no cost to implement this administrative regulation.
(b) On a continuing basis: There is no continuing cost.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): These members’ accounts will remain in compliance with the Internal Revenue Code and thereby avoid potential penalties and additional taxation.
(6) What is the source of funding to be used for the implementation and enforcement of this administrative regulation: Administrative expenses of the retirement system are paid by trust and agency funds.
(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: There is no increase in fees or funding required.
(8) State whether or not the administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees or directly or indirectly increase any fees.
(9) TIERING: Is tiering applied? Tiering is not applied, as all members are treated equally in the calculations performed to determine whether they are subject to the benefit limitations of 26 U.S.C. 415(b).

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT
1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Teachers’ Retirement System.
2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 161.611; 26 C.F.R. 1.415; 26 U.S.C. 125, 132(f)(4), 402, 414, 415, 417, 457, 3401, 6041, 6051, 6052.
3. Estimate the effect of this administrative regulation on the
expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. 

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None. 
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None. 
(c) How much will it cost to administer this program for the first year? No costs will be incurred. 
(d) How much will it cost to administer this program for subsequent years? No costs will be incurred. 

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation. 

Revenues (+/-): N/A 
Expenditures (+/-): N/A 
Other Explanation: 

GENERAL GOVERNMENT CABINET 
Kentucky Board of Pharmacy
(Amendment) 

201 KAR 2:074. Pharmacy services in hospitals or other organized health care facilities. 

RELATES TO: KRS 315.010, 315.020, 315.030, 315.121 
STATUTORY AUTHORITY: KRS 315.191(1) 
NECESSITY, FUNCTION, AND CONFORMITY: KRS 315.191(1) requires the Kentucky Board of Pharmacy to establish requirements to regulate and control pharmacies. KRS 315.002 and 315.005 require standards of practice in all settings where drugs are handled and requires the board to insure the safety of all drug products provided to the citizens of Kentucky. This administrative regulation establishes requirements for pharmacy services in hospitals or other organized health care facilities. 

Section 1. (1) "Automated Pharmacy System" means a mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, packaging, counting, labeling, and dispensing of medications, and which collects, controls, and maintains all transaction information and shall be either: 
(a) A decentralized automated pharmacy system that is located outside the pharmacy department, but within the same institution, and under the supervision of a pharmacist; or 
(b) A pharmacy compounding robotics from which medications are prepared for final distribution that require the approval of a pharmacist. 
(2) "Institutional pharmacy" means that portion of an acute care hospital licensed under 902 KAR 20:016 or a pharmacy serving an other[other] organized health care facility which is engaged in the manufacture, production, sale, or distribution of drugs, medications, devices, or other materials used in the diagnosis or treatment of injury, illness, or disease. 
(3) [24] "Investigational drug" means any drug which has not been approved for use in the United States, but for which an investigational drug application has been approved by the FDA. 
(4) [25] "Other organized health care facility" means a facility: 
(a) Whose primary purpose is to provide medical care and treatment to inpatients; and 
1. An intermediate care facility; 
2. A skilled nursing facility; 
3. A hospital other than an acute care hospital licensed under 902 KAR 20:016; 
4. A licensed personal care home; 
5. A licensed family care home; 
6. A nursing home; 
7. A nursing facility; 
8. An intermediate care facility for mental retardation; or 
5(4) "Unit dose distribution" means a system in which drug therapy profiles are maintained in the pharmacy and doses are scheduled, prepared, and delivered in a ready-to-administer form to the patient care area as they are needed. 

Section 2. Pharmacy Administration. (1) General. The pharmacy, organized as a separate department or service, shall be directed by a professionally competent, legally qualified pharmacist. The director of pharmacy services shall be responsible for departmental management and the development and implementation of goals and objectives to meet the needs of the institution. 
(2) Director of pharmacy services. 
(a) The director of pharmacy services shall be thoroughly knowledgeable about institutional pharmacy practice and management. 
(b) If the director of pharmacy services is not employed full time, the institution shall establish an ongoing arrangement in writing with an appropriately qualified pharmacist to provide services required by this administrative regulation and KRS 315.020(1). The director of pharmacy services shall be responsible to the chief executive officer of the institution or his designee. 
(c) If a hospital pharmacy is decentralized, each decentralized section or separate organizational element shall be under the immediate supervision of a pharmacist responsible to the director of pharmacy services. 
(3) Pharmacy personnel. 
(a) The institutional pharmacy shall maintain additional pharmacists in cooperation with the institution's administration, either full time or part time, as they are required to operate safely and effectively to meet the needs of the patients. 
(b) If nonpharmacist personnel are employed, they shall perform all duties under the supervision of a pharmacist and they shall not be assigned, nor shall they perform, duties that are to be performed only by a pharmacist. 
(4) Responsibilities. 
(a) Lines of authority and areas of responsibility within the pharmacy shall be clearly defined. Written job descriptions for all categories of pharmacy personnel shall be prepared and revised as necessary. 
(b) There shall be policies and procedures to provide for selection of drugs as well as a distribution system to serve the needs of the patient. Provision for procurement of drugs in an emergency situation shall be provided for. 
(5) Supportive personnel. 
(a) Sufficient supportive personnel (technical, clerical, and other) shall be available in order to optimize the participation of pharmacists in activities requiring professional judgment. 
(b) The training and supervision of supportive personnel shall be the responsibility of the pharmacist. 
(6) Availability. 
(a) The services of a pharmacist shall be available at all times. However, if around-the-clock operation of the pharmacy is not feasible, the pharmacist shall be available on an on-call basis and an adequate night drug cabinet shall be established. The pharmacy itself shall not be designated as the night drug cabinet. 
(b) A hospital [hospitals] not having a full-time pharmacist, but in which drugs are prepackaged or relabeled or transferred from one container to another, shall obtain a pharmacy permit and have at least a part-time pharmacist designated to perform those functions or to provide personal supervision of those functions. 

Section 3. Physical Facility. (1) The institutional pharmacy shall have adequate space, equipment, and supplies sufficient to provide for safe and efficient drug storage, preparation, and distribution, patient education and consultation, drug information services, and proper management of the department. 
(2) Legal requirements. The physical facility shall meet state and federal regulations and shall be accessible by authorized pharmacy personnel only. 
(3) (3) Section 3. Physical Facility. (1) The institutional pharmacy shall have adequate space, equipment, and supplies sufficient to provide for safe and efficient drug storage, preparation, and distribution, patient education and consultation, drug information services, and proper management of the department. 
(2) Legal requirements. The physical facility shall meet state and federal regulations and shall be accessible by authorized pharmacy personnel only. 
(3) (3) A currently licensed hospital shall be exempt from the provisions of subsection (2) of this section if it: 
1. Is authorized by the Department for Health and Human Services to provide pharmacy services; and 
2. Does not currently possess a pharmacy permit.
his section shall permit access by authorized licensed practitioner. The institutional pharmacy shall provide floor stock (e.g., emergency autonomas. All permit holders shall comply with the requirements of state and federal law.

(5) Patient medication profile. A medication profile shall be maintained for all inpatients and for those ambulatory patients routinely receiving care at the institution. The pharmacist shall utilize this profile to properly review scheduled, prepare, and distribute medications except in an emergency situation.

(6) Labeling and packaging.

(a) Each licensee shall comply with U.S.P. Standards established pursuant to federal law and all state and federal laws and regulations regarding labeling and packaging.

(b) Labeling and packaging of medications used for outpatients shall meet the requirements of state and federal law.

(7) Dispensing. The pharmacist shall dispense medications by the unit dose distribution system if feasible. If the unit dose distribution system is not utilized, adequate safeguards shall be in place to protect patients.

(8) Stop orders. There shall be established written stop order policies or other methods of assuring that drug orders are not continued inappropriately in accordance with the status of the patient.

(9) Administration. Drugs shall be administered only upon order of a licensed practitioner. The institutional pharmacy shall participate in the establishment of policies and procedures regarding the administration of medications. Specific procedures shall be developed in cooperation with appropriate hospital or other health care facility personnel and shall include personnel authorization to schedule, prepare, and administer medications.

(10) Unused medication. The institutional pharmacy shall establish policies and procedures for the disposition of patients’ unused medications. Medication in unit dose form may be reissued if package integrity has been maintained and the product is still in date.

(11) Hospital floor stocks.

(a) Floor stocks of drugs shall be kept as small as possible. The pharmacist in charge shall be responsible for authenticating the need for floor stock.

(b) A pharmacist shall review all orders distributed through floor stock within a reasonable amount of time.

(c) The pharmacist in charge shall be responsible for defining those areas of the hospital requiring floor stock (e.g., emergency room, surgery, critical care, or medical or surgical wards).

(d) All drug storage areas within the institution shall be routinely inspected by pharmacy personnel at least monthly and documentation maintained to assure that no unusable items are present and that all stock items are properly labeled and stored.

(e) This subsection shall not apply to other organized health care facilities.

(12) Drug recall. There shall be a system for removing from use any drugs subjected to a recall.

(13) Sample medications. The institutional pharmacy shall establish policies and procedures regarding medical representatives and the obtaining, storage, and dispensing of complimentary packages of medications.

(14) Emergency drugs.

(a) The institutional pharmacy shall establish policies and procedures for supplying emergency drugs.

(b) For expediency and efficiency, emergency drugs shall be limited in number to include only those whose prompt use and immediate availability are generally regarded by physicians as essential in the proper treatment of sudden and unforeseen patient emergencies.

(c) Emergency stocks shall be routinely inspected by pharmacy personnel on a monthly basis and documentation maintained to determine if contents have become outdated and if the stocks are being maintained at adequate levels.

(15) Investigational drugs.

(a) Policies and procedures controlling the use of investigational drugs (if used in the institution) shall be developed and followed.

(b) The pharmacy shall be responsible for storing, packaging, labeling, distributing, maintaining inventory records (including lot numbers and expiration dates) and providing information about investigational drugs (including proper disposal).

(16) Controlled substances. All permit holders shall comply with state and federal laws regarding controlled substances.

Section 4. Drug Distribution and Control. (1) General. The institutional pharmacy shall be responsible for the procurement, distribution, and control of all drugs and parenteral solutions used within the institution. The procedures governing these functions shall be developed by the pharmacist with input from other involved hospital or other organized health care facility staff (e.g., nurses) and committees (e.g., pharmacy and therapeutics committee and patient care committee).

(2) Dispenning. The pharmacist shall dispense medications only on the order of a licensed practitioner.

(3) Prescriber’s order. The pharmacist shall review the medication order within a reasonable amount of time.

(4) Recordkeeping. The pharmacist shall maintain appropriate records of each medication order. The records shall be retained for the time and in the manner prescribed by state and federal law.

(5) Patient medication profile. A medication profile shall be maintained for all inpatients and for those ambulatory patients routinely receiving care at the institution. The pharmacist shall utilize this profile to properly review, schedule, prepare, and distribute medications except in an emergency situation.

(6) Labeling and packaging.

(a) Each licensee shall comply with U.S.P. Standards established pursuant to federal law and all state and federal laws and regulations regarding labeling and packaging.

(b) Labeling and packaging of medications used for outpatients shall meet the requirements of state and federal law.

(7) Dispensing. The pharmacist shall dispense medications by the unit dose distribution system if feasible. If the unit dose distribution system is not utilized, adequate safeguards shall be in place to protect patients.

(8) Stop orders. There shall be established written stop order policies or other methods of assuring that drug orders are not continued inappropriately in accordance with the status of the patient.

(9) Administration. Drugs shall be administered only upon order of a licensed practitioner. The institutional pharmacy shall participate in the establishment of policies and procedures regarding the administration of medications. Specific procedures shall be developed in cooperation with appropriate hospital or other health care facility personnel and shall include personnel authorization to schedule, prepare, and administer medications.

(10) Unused medication. The institutional pharmacy shall establish policies and procedures for the disposition of patients’ unused medications. Medication in unit dose form may be reissued if package integrity has been maintained and the product is still in date.

(11) Hospital floor stocks.

(a) Floor stocks of drugs shall be kept as small as possible. The pharmacist in charge shall be responsible for authenticating the need for floor stock.

(b) A pharmacist shall review all orders distributed through floor stock within a reasonable amount of time.

(c) The pharmacist in charge shall be responsible for defining those areas of the hospital requiring floor stock (e.g., emergency room, surgery, critical care, or medical or surgical wards).

(d) All drug storage areas within the institution shall be routinely inspected by pharmacy personnel at least monthly and documentation maintained to assure that no unusable items are present and that all stock items are properly labeled and stored.

(e) This subsection shall not apply to other organized health care facilities.

(12) Drug recall. There shall be a system for removing from use any drugs subjected to a recall.

(13) Sample medications. The institutional pharmacy shall establish policies and procedures regarding medical representatives and the obtaining, storage, and dispensing of complimentary packages of medications.

(14) Emergency drugs.

(a) The institutional pharmacy shall establish policies and procedures for supplying emergency drugs.

(b) For expediency and efficiency, emergency drugs shall be limited in number to include only those whose prompt use and immediate availability are generally regarded by physicians as essential in the proper treatment of sudden and unforeseen patient emergencies.

(c) Emergency stocks shall be routinely inspected by pharmacy personnel on a monthly basis and documentation maintained to determine if contents have become outdated and if the stocks are being maintained at adequate levels.

(15) Investigational drugs.

(a) Policies and procedures controlling the use of investigational drugs (if used in the institution) shall be developed and followed.

(b) The pharmacy shall be responsible for storing, packaging, labeling, distributing, maintaining inventory records (including lot numbers and expiration dates) and providing information about investigational drugs (including proper disposal).

(16) Controlled substances. All permit holders shall comply with state and federal laws regarding controlled substances.

Section 5. Assuring Rational Drug Therapy. (1) Appropriate clinical information about patients shall be available and accessible to the pharmacist for use in controlling practice activities.

(2) The pharmacist shall be a member of the pharmacy and therapeutics committee and any other committees where input concerning the use of drugs is required.

(3) The pharmacist shall provide a means to assure that patients receive adequate information about the drugs they receive. Patient education activities shall be in coordination with the nursing and medical staffs and patient education department, if any.

Section 6. Responsibility. The pharmacist-in-charge of a pharmacy utilizing an automated pharmacy system shall be responsible for:

(1) An initial validation of system accuracy prior to use for distribution to patients;

(2) Ensuring the system:

(a) Is properly maintained;

(b) Is in good working order;

(c) Accurately dispenses the correct strength, dosage form, and quantity of drug prescribed;

(d) Complies with the recordkeeping, access, and security safeguards pursuant to all applicable state and federal laws;

(3) Assuring medications are reviewed prior to loading into any automated pharmacy system and distribution;

(4) Implementing an ongoing quality assurance program that monitors performance of the pharmacy compounding robotics, which is evidenced by written policies and procedures and requires a continued documented validation of doses distributed on a routine and annual review of the quality assurance program.

(5) Establishing policies and procedures if there is a system failure of any automated pharmacy system;

(6) Providing the board with prior written notice of installation or removal of any automated pharmacy system. This notification shall include the:

(a) Name and address of the pharmacy; and

(b) Initial location of the automated pharmacy system;

(7) Oversight for assigning, discontinuing, or changing personnel access to the system, including establishment of written policies and procedures for security and control;

(8) Reviewing personnel access on at least an annual basis;

(9) Assuring that the decentralized automated pharmacy system stock is checked at least monthly in accordance with established policies and procedures, including checking for...
(a) Accuracy;
(b) Integrity of packaging; and
(c) Expiration dates;
(10) Maintaining in the pharmacy the following documentation relating to an automated pharmacy system:
(a) The name and address of the pharmacy or inpatient health care facility where the system is being used;
(b) The automated pharmacy manufacturer’s name, model, serial number, and software version;
(c) A description of how the system is used;
(d) Written quality assurance procedures and accompanying documentation of use to determine continued appropriate use of the system as established in subsection (7) and (8) of this section; and
(e) Written policies and procedures for system operation, safety, security, accuracy, emergency medication access, access, and malfunction which includes clearly defined down time and procedures; and
(11) Maintaining adequate security systems and procedures, evidenced by written policies and procedures to:
(a) Prevent unauthorized access;
(b) Maintain patient confidentiality;
(c) Allow user access modification; and
(d) Comply with federal and state laws.

Section 7. Standards, (1) (a) All events involving the contents of the automated pharmacy system shall be recorded electronically.
(b) Records shall be maintained by the pharmacy and be available to the board and shall include the following:
1. The date, time, and location of the system accessed;
2. Identification of the individual accessing the system;
3. Type of transaction;
4. Name, strength, dosage form, and quantity of drug accessed; and
5. Name of the patient for whom the drug was ordered, if applicable.
(2) All medications to be stocked in the pharmacy compounding robotics shall have been previously validated for bar code accuracy by a pharmacist, pharmacist intern, or certified pharmacy technician. Integrity and accuracy shall be validated by a pharmacist.
(3) The stocking of medications in a decentralized automated pharmacy system utilizing bar code technology shall be done by a pharmacist, pharmacist intern, or a certified pharmacy technician.
(4) The stocking of medications in a decentralized automated pharmacy system without bar code technology shall be done by a pharmacist, pharmacist intern, or a certified pharmacy technician. Integrity and accuracy shall be validated by a pharmacist.
(5) If the hospital licensed under 902 KAR 20:016 utilizes technology that validates appropriate drug, dose, dosage form, route of administration, time of administration, and patient at the exact time of medication administration, the stocking of the decentralized automated pharmacy system shall be done by a pharmacist, pharmacist intern, or a certified pharmacy technician.
(6) A record of medications stocked in an automated pharmacy system shall be maintained for five (5) years and shall include:
(a) The name of the person repacking the medications; and
(b) Documentation of the pharmacist checking the medications.
(7) All containers of medications stored in the automated pharmacy system shall be packaged and labeled in accordance with federal and state laws.
(8) The automated pharmacy system shall provide a mechanism for securing and accounting for medications removed from and subsequently returned to the automated pharmacy system, in accordance with federal and state laws.
(9) All medications initially received in the pharmacy for use in an automated pharmacy system shall be quarantined until validation of bar code accuracy and existence of the item in the database powering automated pharmacy system by a certified pharmacy technician, pharmacist intern, or pharmacist.
(10) If a medication needs to be repackaged:
(a) A pharmacist, pharmacist intern, or certified pharmacy technician shall:
1. Perform the repacking and validate the presence of an accurate bar code on the unit dose packaging; and
2. Document the repackaging process including:
   a. Manufacturer;
   b. Date and time of repackaging;
   c. The person repackaging;
   d. The lot number or batch number;
   e. The expiration date; and
   f. The quantity repackaged; and
(b) A pharmacist shall:
1. Validate for accuracy and integrity prior to the addition to the automated pharmacy system; and
2. Document the validation including:
   a. The date and time of the validation;
   b. The name of the pharmacist validating;
   c. The lot number or batch number;
   d. The expiration date; and
   e. The quantity validated.
(11) A medication returned to the pharmacy from a patient care area shall follow the procedures established pursuant to Section 4(10) of this administrative regulation.
(12) A medication distributed by the pharmacy compounding robotics shall be distributed in the delivery device utilized by that system.
(13) A medication distributed by an automated pharmacy system shall be accessed and administered by a professional licensed to administer medications.

JOEL THORNBURY, President
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Thursday, February 28, 2013 at 9:00 a.m. at the Board’s office, State Office Building Annex, Suite 300, 125 Holmes Street, Frankfort, Kentucky 40601. Individuals interested in attending this hearing shall notify this agency in writing by five workdays prior to this hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until Thursday, February 28, 2013 at 11:59 p.m. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:
CONTACT PERSON: Michael Burleson, Executive Director, Kentucky Board of Pharmacy, State Office Building Annex, Suite 300, 125 Holmes Street, Frankfort, Kentucky 40601, phone (502) 564-7910, fax (502) 696-3806.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Michael Burleson
(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the board procedure for automated pharmacy systems in hospitals.
(b) The necessity of this administrative regulation: This regulation is necessary to establish procedures for automated pharmacy systems in hospitals.
(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation is in conformity with the content of the authorizing statutes: This regulation is necessary to establish procedures for automated pharmacy systems in hospitals.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation delineates the procedures for automated pharmacy systems in hospitals.
(e) If this is an amendment to an existing administrative regulation, provide a brief summary of:
   (a) How the amendment will change this existing administrative regulation: This amendment will establish new procedures for automated pharmacy systems in hospitals.
   (b) The necessity of the amendment to this administrative regu-
station: Requires the board to set procedures for automated pharmacy systems in hospitals.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment authorizes the board to promulgate regulations regarding the requirements for pharmacies.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will require the board to have procedures in place regarding automated pharmacy systems in hospitals.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: The board anticipates that this will affect any hospital utilizing an automated pharmacy system.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation: Hospitals that utilize an automated pharmacy system will have policies and procedures that shall be followed. (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): None.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Hospital pharmacies will have a regulation that will provide them with requirements regarding an automated pharmacy system.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: No new costs initially.

(b) On a continuing basis: No costs on a continuing basis.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: No funding is required.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: None.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation will not establish a fee.

(9) TIERING: Is tiering applied? Tiering was not applied as the administrative regulation is applicable to any hospital pharmacy.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Board of Pharmacy will be impacted by this administrative regulation.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 315.191(1) requires or authorizes the action taken by this administrative regulation.

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect:

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? None.

(d) How much will it cost to administer this program for subsequent years? None.

(4) If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation:

Revenues (+/-):
Expenditures (+/-):
Other Explanation:
time.

(2) Except as provided in subsection (3) of this section, if after a review of a provider it is determined that the provider does not comply with this administrative regulation, the board shall send the provider notice of its intent to deny or limit the provider’s approval status.

(3) If after a review of a continuing education activity or refresher course it is determined that the activity does not comply with this administrative regulation, the board shall send the provider notice of its intent to deny approval status for subsequent offerings of that specific continuing education activity.

(4)(a) A request for a hearing before the board shall be filed within ten (10) days of receipt of the board’s notice.

(b) If a provider fails to submit a request for a hearing within the time specified in paragraph (a) of this subsection, the board shall implement the action proposed in its notice.

Section 4(3). Providers shall comply with the following standards:

(1)(a) A nurse who meets the qualifications specified in paragraph (b) of this subsection shall be administratively responsible for continuing education activities, including:

1. Planning;
2. Development;
3. Implementation; and
4. Evaluation.

(b) A nurse administrator shall:

1. Hold a current active license;
2. Have experience in adult and continuing education; and
3. Hold a baccalaureate or higher degree, in nursing.

(c) The provider shall designate an alternate nurse administrator who shall meet the requirements of paragraph (b) of this subsection.

(2) Organized learning activities shall be based upon a reasonable justification supporting the need for the systematic needs assessment, and shall support quality continuing education that:

(a) Enhances the quality, safety and effectiveness of care provided by nurses; and
(b) Contributes directly to the competence of a nurse.

(3) The content of nursing continuing education shall be designed to:

(a) Present current theoretical knowledge to enhance and expand nursing skills; and
(b) Promote the development, or change in attitudes, necessary to make competent judgments and decisions in nursing.

(4) Outcomes [Objectives] for continuing education activities shall be:

(a) Related to nursing practice and interventions;
(b) Stated in clearly defined expected learner outcomes; and
(c) Consistent with evidence of a need for the continuing education activity or refresher course [needs assessment data].

(5) The continuing education activity shall reflect cooperative planning between the nurse administrator, faculty and content experts.

(6) The content for each educational activity shall include and be documented in provider files as follows:

(a) An agenda indicating a presentation schedule, presenters, topics, meals, breaks.
(b) Outline format with corresponding time frames, teaching methods indicated for each content area. The content shall be related to and consistent with the outcome [Topical outline, teaching methods, and corresponding time frames sufficient to support relevance and value of the educational activity to safe, effective nursing practice].
(c) The outcomes shall provide statements of observable behaviors that present a clear description of the competencies to be achieved by the learner.

(7) Teaching methods shall be consistent with the content and learning objectives, and shall reflect the use of adult learning principles. Activities of both the teacher and the learner shall be specified in relation to the content outline.

(8) Faculty for continuing education activities and refresher courses shall have:

(a) Documented expertise in the subject matter; and
(b) Experience in presenting to adult learners and facilitating adult learning [demonstrate content knowledge and expertise].

(9) The name, title and credentials identifying the educational and professional qualifications for each faculty member shall be retained in the provider offering files.

(10) Resources allocated for the continuing education activity or refresher course shall be adequate in terms of education unit organization, with fiscal support for adequate staff, facilities, equipment and supplies to ensure quality teaching-learning in a comfortable environment that is accessible to the target audience.

(11) Participants shall be provided with essential information for review prior to registration. This information shall include:

(a) Learner outcomes [Learning objectives];
(b) Content overview;
(c) Date, time, and presentation schedule;
(d) Presenter;
(e) Number of contact hours;
(f) Fee and refund policy; [and]
(g) Target audience and any prerequisites; and
(h) Requirements for successful completion that shall be clearly specified and shall include a statement of policy regarding candidates who fail to successfully complete the offering.

(12) Published information about continuing education activities offered by providers approved by the board shall include the provider number:

(a) Provider number; and
(b) Following statement: "Kentucky Board of Nursing approval of an individual nursing continuing education provider does not constitute endorsement of program content."

(13)(a) A provider shall notify the board in writing within one (1) month of any changes in its administration, such as nurse administrator, mailing address, telephone number or other relevant information.

(b) Information relevant to the qualifications of the new nurse administrator as set forth in subsection (1)(b) of this section shall be sent to the board.

(c) If a qualified nurse is not available to serve in the capacity of the administrator, the provider shall not offer any continuing education activity or refresher course until a qualified nurse administrator is appointed.

(14) A provider shall designate and publish the number of hours of any portion of an offering dedicated to pharmacology.

(15) Records of continuing education activities shall be maintained for a period of five (5) years, except for HIV/AIDS education which shall be maintained for at least twelve (12) years, including the following:

(a) Title, date and site of the activity;
(b) Name of the person responsible for coordinating and implementing the activity;
(c) Purpose, documentation of planning committee activities, learner outcomes [objectives], content outline, faculty, teaching and evaluation methods;
(d) Participant roster, with a minimum of:
1. Name; and
2. Social Security number or license number;
(e) Summary of participant evaluations;
(f) Number of continuing education contact hours awarded;
1. Contact hours shall be calculated by taking the total number of minutes that the participants will be engaged in the learning activities, excluding breaks, and divide by fifty (50):
2. Partial hours are not permissible after one (1) contact hour is earned;
(g) Master copy of certificate awarded; and
(h) All required instructional materials and references shall be identified.

(16) Participants shall receive a certificate of completion [attendance] that documents participation with the following:

(a) Name of participant;
(b) Offering title, date and location;
(c) The [KBN's] provider's name, address, telephone number, approval number and expiration date of the provider's;
(d) Name and signature of authorized provider representative;
(e) Number of continuing education contact hours awarded.

(17) There shall be a clearly defined method for evaluating the continuing education activity which includes the following:

(a) An evaluation tool that includes participant appraisal of achievement of each outcome (learning objective); teaching effectiveness of each presenter; relevance of content to stated outcomes (objectives); effectiveness of teaching methods; and appropriateness of physical facilities.

(b) A mechanism for periodic, systematic evaluation of the provider’s total program of educational activities.

(18) There shall be a summary of the participants’ evaluations for each continuing education activity or refresher course with an action plan with time lines for resolution of identified deficiencies [shall be maintained].

(19) The provider shall have current policies and procedures for the management of the providership that demonstrate compliance with the required standards.

(20) For an offering that includes clinical practice, the instructor-to-patient ratio shall be one (1) to ten (10) [The continuing education provider shall be a recognizable function within the sponsoring organization].

(21) The following constitute in-service education and shall not be considered as a continuing education activity for purposes of this administrative regulation:

(a) An activity that is part of an employing agency’s staff development program designed to provide information related to the work setting;

(b) On the job training;

(c) Orientation;

(d) Basic cardiopulmonary resuscitation; and

(e) Equipment demonstration.

Section 5(4). (1) The following forms are incorporated by reference:

(a) “Application for Provider Approval”, 10/2012 [62005], Kentucky Board of Nursing;

(b) “Application for Provider Renewal”, 10/2012 [62005], Kentucky Board of Nursing.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222, Monday through Friday, 8 a.m. to 4:30 p.m.

SALLY BAXTER, President
APPROVED BY AGENCY: October 11, 2012.

FILED WITH LRC: January 10, 2013 at 1 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 26, 2013 at 1:00 p.m. (EST) in the office of the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky. Individuals interested in being heard at this hearing shall notify this agency in writing by February 19, 2013, five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until close of business February 28, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Nathan Goldman, General Counsel, Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222, phone (502) 429-3309, fax (502) 564-4251, email: nathan.goldman@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Nathan Goldman

(1) Provide a brief summary of:

(a) What this administrative regulation does: It sets out the requirements for approval of continuing education (CE) providers.

(b) The necessity of this administrative regulation: It is required by statute.

(c) How this administrative regulation conforms to the content of the authorizing statutes: By setting out requirements.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By setting out requirements.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The provisions of 201 KAR 20:380 on refresher courses are being transferred to this administrative regulation for efficiency. In addition, this amendment makes several updates in the approval process.

(b) The necessity of the amendment to this administrative regulation: The Board strives for regulatory efficiency and to have current requirements.

(c) How the amendment conforms to the content of the authorizing statutes: By setting the approval requirements.

(d) How the amendment will assist in the effective administration of the statutes: By setting requirements.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: CE providers, of which the Board currently has approved 219.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There is no additional cost to comply. The application fees remain the same.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will be in compliance with the statute and regulation.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: There is no additional cost.

(b) On a continuing basis: There is no additional cost.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Agency funding.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase is needed.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: It does not.

(9) TIERING: Is tiering applied? Tiering was not applied as the changes apply to all equally.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Nursing

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 314.073, 314.131

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect:

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? Unknown,
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? Unknown.

(c) How much will it cost to administer this program for the first year? There is no additional cost.

(d) How much will it cost to administer this program for subsequent years? There is no additional cost.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): Revenues are generated through application fees. The amount received will depend on the number of new applicants, which is unknown.

Expenditures (+/-): Existing staff can handle the new changes.

Other Explanation:

GENERAL GOVERNMENT CABINET
Kentucky Board of Interpreters for the Deaf and Hard of Hearing
(AMENDMENT)

201 KAR 39:030. Application; qualifications for licensure; and certification levels.

RELATES TO: KRS 309.304(1), 309.312(1)(b)
STATUTORY AUTHORITY: KRS 309.304(3), 309.312(1)(b)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 309.304(3) and 309.312(1)(b) require the Kentucky Board of Interpreters for the Deaf and Hard of Hearing to promulgate an administrative regulation establishing the requirements for an applicant for licensure as an interpreter for the deaf and hard of hearing. This administrative regulation establishes these requirements.

Section 1. Application. Each applicant for a license shall:
(1) Submit a completed Application for Licensure form to the board;
(2) Pay the application and license fee as set forth in 201 KAR 39:040; and
(3) Submit proof of valid certification:
(a) At a level recognized by RID, with the exception of NAD III;
(b) At EIPA level 3.5 and passage of the EIPA written if applying on or prior to July 1, 2013;
(c) TECUnit; or
(d) Other certifications as described in 201 KAR 39:080, if applying for licensure via reciprocity.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Division of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

TIM OWENS, Board Chair
APPROVED BY AGENCY: January 2, 2013
FILED WITH LRC: January 10, 2013 at 3 p.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2013 at 8:00am (EST) at 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until 11:59 pm (EST) on February 28, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Karen Lockett, Board Administrator, Kentucky Board of Interpreters for the Deaf and Hard of Hearing, PO Box 1370, Frankfort, Kentucky 40602, phone (502) 564-3296, ext. 222, fax (502) 696-1923.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Michael West
(1) Provide a brief summary of:
(a) What this administrative regulation does: This regulation establishes application requirements for one applying to be an interpreter.
(b) The necessity of this administrative regulation: This regulation is necessary to provide appropriate procedures for the application process for becoming a licensed interpreter.
(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation is in conformity as the authorizing statute gives the board the ability to promulgate regulations generally.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation will assist the board in administering this program by ensuring that prospective licensees have a clear understanding of the process for obtaining a license and requirements.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment edits incorporated forms.
(b) The necessity of the amendment to this administrative regulation: The necessity of amendment is to provide accurate information on the forms.
(c) How the amendment conforms to the content of the authorizing statutes: The regulation is in conformity as the authorizing statute gives the board the ability to promulgate regulations generally related to the practice of interpreting.
(d) How the amendment will assist in the effective administration of the statutes: The amendment will clarify the requirements for obtaining a license to potential licensees.
(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are approximately 300 full and temporarily licensed interpreters. This regulation only impacts those applying for initial licensure.
(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Prospective licensees will need to meet the requirements for licensure specified in the regulation.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the identified entities in question (3): Possibly fees associated with the exam that the individual selects to become licensed and normal application and licensure fees as established by regulation.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The prospective licensees will have the opportunity to become licensed if they meet the requirements of the regulation.
(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: No new costs will be incurred by the changes.
(b) On a continuing basis: No new costs will be incurred by the changes.
(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The board's operations are funded by fees paid by licensees.
(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No fees will be required to implement this administrative regulation amendment.
(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This regulation does not establish fees.

(9) TIERING: Is tiering applied? Tiering is not applied to this regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Contact Person: Michael West
(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Interpreters for the Deaf and Hard of Hearing
(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 309.304(3)
(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None
(a) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None
(c) How much will it cost to administer this program for the first year? None
(d) How much will it cost to administer this program for subsequent years? None

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

GENERAL GOVERNMENT CABINET
Kentucky Board of Interpreters for the
Deaf and Hard of Hearing
(AMENDMENT)

201 KAR 39:050. Renewal of licenses, extension of temporary licenses and reinstatement.

RELATES TO: KRS 309.304(5), 309.312, 309.314
STATUTORY AUTHORITY: KRS 309.304(3), 309.312, 309.314
NECESSITY, FUNCTION, AND CONFORMITY: KRS 309.304(3), 309.312, and 309.314 require the Board of Interpreters for the Deaf and Hard of Hearing to promulgate administrative regulations to carry the provisions of KRS 309.300 to 309.3189; to establish certification requirements for licensees; and to establish renewal and reinstatement fees. This administrative regulation establishes requirements for renewal of licenses, extension of temporary licenses, and reinstatement.

Section 1. Renewal of Licenses. A person licensed as an interpreter shall renew that license annually, as required by KRS 309.314(1) by submitting the following to the board:
(1) A completed License Renewal Application form;
(2) The renewal fee as established in 201 KAR 39:040;
(3) Proof of current certification of the licensee as established in 201 KAR 39:030; and
(4) Documentation of completion of the continuing education requirement established in 201 KAR 39:090.

Section 2. Grace Period. If a license is not renewed by July 1, it may be renewed during the following sixty (60) day period, in accordance with KRS 309.314, by:
(1) Complying with the requirements established in Section 1 of this administrative regulation; and
(2) Submitting the late renewal fee established in 201 KAR 39:040.

Section 3. (1) Reinstatement. A license not renewed prior to the close of the sixty (60) day grace period, in accordance with KRS 309.314(4), may be reinstated upon:
(a) Payment of the renewal fee plus a reinstatement fee as established by 201 KAR 39:040, Section 4(1);
(b) Submission of a completed License Reinstatement Application form to the board;
(c) Submission of evidence of completion of continuing education as required by 201 KAR 39:090, Section 10; and
(d) Completion of the requirements of Section 4 of this administrative regulation.
(2) The board may reinstate a temporary license only if the licensee submits proof sufficient to the board of situations such as:
(a) Medical disability of the licensee;
(b) Illness of the licensee or an immediate family member;
(c) Death or serious injury of an immediate family member.
(3) A request for reinstatement of a temporary license involving medical disability or illness shall be:
(a) Submitted by the person holding a license; and
(b) Accompanied by a verifying document signed by a licensed physician.

Section 4. Extensions of Temporary Licenses. To request an extension of a temporary license:
(1) A temporary licensee shall submit:
(a) A completed Temporary License Extension Application form;
(b) The appropriate fee set forth in 201 KAR 39:040;
(c) Proof of completion of the continuing education requirements set forth in 201 KAR 39:090;
(d) A letter recommending extension written by the Mentor(s) of Record for the previous licensure term which describes the progress achieved by the mentee. The board may waive this requirement upon submission of proof by the licensee that the licensee has substantially met the goals stated in the plan of supervision; and
(e) A revised plan of supervision for the upcoming licensure year.
(2) A deaf or hard of hearing temporary licensee shall submit:
(a) Upon applying for a first, second, or third extension:
1. A completed Temporary License Extension Application form;
2. The appropriate fee set forth in 201 KAR 39:040;
3. Proof of completion of the continuing education requirements set forth in 201 KAR 39:090;
4. A letter recommending extension written by the Mentor(s) of Record which describes the progress achieved by the Mentee. The board may waive this requirement upon submission of proof by the licensee that the licensee has substantially met the goals stated in the plan of supervision; and
5. A revised plan of supervision for the upcoming licensure year.
(b) Upon applying for a fourth and subsequent extensions:
1. All requirements listed in paragraph (a) of this subsection; and
2. Proof of passage of the RID CDI Knowledge Exam.
(3) The extensions of temporary licenses under this section shall be subject to the term limitations imposed by 201 KAR 39:070(2).

Section 5. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) "License Renewal Application", January 2013(10/2011).
(b) "License Reinstatement Application", January 2013(10/2011).
(c) "Temporary License Reinstatement Application", January 2013; and
(d) "Temporary License Extension Application", January 2013(10/2011).
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(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Division of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

TIM OWENS, Board Chair
APPROVED BY AGENCY: January 2, 2013
FILED WITH LRC: January 10, 2013 at 3 p.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2013 at 8:00am (EST) at 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will be made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until 11:59 pm (EST) on February 28, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Karen Lockhart, Board Administrator, Kentucky Board of Interpreters for the Deaf and Hard of Hearing, PO Box 1370, Frankfort, Kentucky 40602, phone (502) 564-3296, ext. 222, fax (502) 696-1923.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Michael West
1. Provide a brief summary of:
(a) What this administrative regulation does: This regulation establishes renewal application requirements for one applying to be an interpreter.
(b) The necessity of this administrative regulation: This regulation is necessary to provide appropriate procedures for the application process for renewing a license as an interpreter.
(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation is in conformity as the authorizing statute gives the board the ability to promulgate regulations generally.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation will assist the board in administering this program by ensuring that prospective licensees have a clear understanding of the process for obtaining a license and requirements.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment edits incorporated forms.
(b) The necessity of the amendment to this administrative regulation: The necessity of amendment is to provide accurate information on the forms.
(c) How the amendment conforms to the content of the authorizing statutes: The regulation is in conformity as the authorizing statute gives the board the ability to promulgate regulations generally related to the practice of interpreting.
(d) How the amendment will assist in the effective administration of the statutes: The amendment will clarify the requirements for obtaining a license to potential licensees.
3. List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are approximately 300 full and temporarily licensed interpreters. This regulation only impacts those applying for initial licensure.
4. Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Prospective licensees will need to meet the requirements for licensure specified in the regulation.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Possibly fees associated with the exam that the individual selects to become licensed and normal application and licensure fees as established by regulation.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The prospective licensees will have the opportunity to become licensed if they meet the requirements of the regulation.
(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: No new costs will be incurred by the changes.
(b) On a continuing basis: No new costs will be incurred by the changes.
(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The board’s operations are funded by fees paid by licensees.
(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No fees will be required to implement this administrative regulation amendment.
(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This regulation does not establish fees.
(9) TIERING: Is tiering applied? Tiering is not applied to this regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Interpreters for the Deaf and Hard of Hearing
(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 309.304(3)
(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None
(a) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None
(b) In comply
(4) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None
(c) How much will it cost to administer this program for the first year? None
(d) How much will it cost to administer this program for subsequent years? None
Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

GENERAL GOVERNMENT CABINET
Kentucky Board of Prosthetics, Orthotics and Pedorthics
(Amendment)

201 KAR 44:090. Requirements for licensure as an orthot-
ist, prosthetist, orthotist-prosthetist, pedorthist, or orthotic
fitter on or after January 1, 2013.

RELATES TO: KRS 319B.010, 319B.030, 319B.110
STATUTORY AUTHORITY: KRS 319B.030(1), (2), 319B.110
NECESSITY, FUNCTION, AND CONFORMITY: KRS
319B.030(1) requires the board to establish licensure categories and issue licenses for persons who wish to practice in this state as a licensed orthotist, licensed prosthetist, licensed orthotist-prosthetist, licensed pedorthist, or licensed orthotic fitter. This administrative regulation establishes the procedure by which those applicants shall apply for a license pursuant to KRS 319B.030.

Section 1. Licensure of an Orthotist, Prosthetist or Orthotist-Prosthetist. An applicant for licensure as an orthotist, prosthetist, or orthotist-prosthetist shall submit:
(1) A completed "Application for Licensure", Form BPOP1; (2) A certified copy of the applicant’s transcript from an accredited college or university showing a minimum of a baccalaureate degree awarded to the applicant; (3) A certified copy of the applicant’s education program in orthotics, prosthetics, or both from an educational program accredited by the Commission on Accreditation of Allied Health Education Program; (4) Proof of completion of a residency meeting the standards established in KRS 319B.010(26) for the discipline for which the applicant has applied; (5) Proof of the applicant’s having obtained a passing score on the American Board of Certification (ABC) examination or the Board of Certification/Accreditation International (BOC); (6) The appropriate fee for licensure as required by 201 KAR 44:010; and (7) Detailed work history, including scope of practice, covering the four (4) year period immediately prior to the date of application.

Section 2. Licensure of a Pedorthist. An applicant for licensure as a pedorthist shall submit:
(1) A completed "Application for Licensure", Form BPOP1; (2) A certified copy of high school diploma or comparable credential; (3) Proof of completion of an NCOPE- approved pedorthic education program; (4) Proof of passing the American Board of Certification (ABC) exam or Board of Certification/Accreditation International (BOC); (5) Proof of a minimum of 1,000 hours of pedorthic patient care, 500 hours shall be completed after the NCOPE- approved education program; (6) The appropriate fee for licensure as required by 201 KAR 44:010; and (7) A detailed work history, including scope of practice, covering the four (4) year period prior to the date of application.

Section 3. Licensure of an Orthotic Fitter. An applicant for licensure as an orthotic fitter shall submit:
(1) A completed "Application for Licensure", Form BPOP1; (2) A certified copy of high school diploma or comparable credential; (3) Proof of completion of an NCOPE- approved orthotic fitter education program; (4) Proof of passing the American Board of Certification (ABC) exam or Board of Certification/Accreditation International (BOC); (5) Proof of a minimum of 1,000 hours of orthotic fitter patient care, 500 hours shall be completed after the NCOPE approved education program; (6) The appropriate fee for licensure as required by 201 KAR 44:010; and (7) A detailed work history, including scope of practice, covering the four (4) year period prior to the date of application.

Section 4. Incorporation by Reference. (1) "Application for Licensure", BPOP1, 01/2013[07/2012], is incorporated by reference.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Prosthetics, Orthotics, and Pedorthics, 911 Leawood Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 5:00 p.m.

SIENNA NEWMAN, Chairperson
APPROVED BY AGENCY: January 3, 2013
FILED WITH LRC: January 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Monday, February 25, 2013 at 10:00 a.m., local time, at the Kentucky Board of Licensure for Orthotists, Prosthetists, Orthotist-Prosthetists, Pedorthists, or Orthotic Fitters, 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) workdays prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until Thursday, February 28, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Angela Evans, Board Counsel, Office of the Attorney General, 700 Capital Avenue, Suite 118, Frankfort, Kentucky 40601, phone (502) 696-5300, fax (502) 564-6801.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Angela Evans
(1) Provide a brief summary of: Establishes the requirements to obtain a license as an Orthotist, Prosthetist, Orthotist/Prosthetist, Pedorthist, or Orthotic Fitter.
(a) What this administrative regulation does: This administrative regulation establishes the procedures for the licensure of persons who wish to practice in the state as a Licensed Orthotist, Licensed Prosthetist, Licensed Orthotist/Prosthetist, Licensed Pedorthist, or Licensed Orthotic Fitter.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to set the process for licensure.
(c) How does this administrative regulation conform to the content of the authorizing statute? KRS Chapter 319B requires the board to establish a procedure for the licensure of persons who wish to practice in the state as a Licensed Orthotist, Licensed Prosthetist, Licensed Orthotist/Prosthetist, Licensed Pedorthist, or Licensed Orthotic Fitter. This administrative regulation establishes the requirements for applicants for licensure.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation informs the applicants of the requirements for the process involved in obtaining licensure from the board.
(e) If this is an amendment to an existing administrative regulation, provide a brief summary of: (a) How the amendment will change this existing administrative regulation: The amendment adds the Board of Certification/Accreditation, International examination as an acceptable examination.
(b) The necessity of the amendment to this administrative regulation: The Board of Certification/Accreditation International (BOC) has now revised its exam and meets the standards of the board. Therefore, the amendment is necessary to include the BOC examination as another acceptable examination option.
(c) How the amendment conforms to the content of the authorizing statute: The amendment still requires an examination that meets the approval of the board.
(d) How the amendment will assist in the effective administration of the statutes: The amendment will reduce the questions regarding examinations, allowing both common providers of the exam to be accepted.
(e) List the type and number of individuals, businesses, organizations, state and local governments affected by this administrative regulation: Businesses providing credentialing examinations for orthotists, prosthetists, pedorthists and orthotic fitters, and the individuals enrolled in these programs. Of the estimated fifty (50) persons who will seek licensure within the next fiscal year, this administrative regulation will also continue as new license new applicants who seek licensure from the board.
(4) Provide an analysis of how the entities identified in question
(3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: This amendment will allow individuals currently gaining admission into BOC to be able to use their examination for licensure.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The amendment does not impact the cost for individuals who might apply for licensure. The board does not have authority over the cost of the examinations.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Individuals seeking licensure will have an option in deciding which examination provider to choose.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
(a) Initially: The budget for the board is $9,000. However, there will be no cost to the board to implement the amendment.
(b) On a continuing basis: The budget for the Board is estimated to continue to have a budget of $9000 per year. However, there will be no cost to the board to implement the amendment.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The board’s operation is funded by fees paid by the licensees and applicants.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: This amendment will not require a change in any fees.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The administrative regulation did not establish the fees only the procedure for obtaining a license but there will be a fee to apply that is set in a separate regulation.

(9) Tiering: Is tiering applied? No, the administrative regulation requires the same documentation to be provided with each type of application to apply to the board in the state as a Licensed Orthotist, Licensed Prosthetist, Licensed Orthotist/Prosthetist, Licensed Pedorthist, or Licensed Orthotic Fitter.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Prosthetics, Orthotics, and Pedorthics Licensing Board.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 319B.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The administrative regulation did not generate additional revenue for the first year.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The revenue will depend on the number of applicants for the subsequent years.

(c) How much will it cost to administer this program for the first year? The budget for the board is $9,000 which pays administrative fees, per diems for board members and legal fees.

(d) How much will it cost to administer this program for subsequent years? The budget for the board is $9,000 which pays administrative fees, per diems for board members and legal fees.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): N/A

Expenditures (+/-): N/A

Other Explanation: N/A

GENERAL GOVERNMENT CABINET
Kentucky Board of Prosthetics, Orthotics and Pedorthics

201 KAR 44:120. Post residency registration.

RELATES TO: KRS 319B.030(1)(c)

STATUTORY AUTHORITY: KRS 319B.030(1)(c)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 319B.030(1)(c) authorizes the board to establish circumstances and conditions for individuals who have completed the required training and established circumstances by which an individual may continue to practice as a prosthetist or orthotist. This administrative regulation establishes the requirements for registration for post residency practice.

Section 1. Eligibility. (1) An orthotic or prosthetic resident, who has successfully completed an NCOPE residency in the appropriate field and prior to completing the American Board for Certification examination or the Board of Certification/Accreditation, International examination, may work in the discipline in which he or she is deemed eligible upon application to and approval by the board.

(2) An applicant shall submit to the board:

(a) A completed Post Residency Registration form;
(b) Documentation of residency completion;
(c) Documentation of application for examination; and
(d) A letter from a supervisory licensed practitioner that monitoring of the applicant will continue.

(3) The exemption shall expire fifteen (15) months from the date of completion of the NCOPE residency.

Section 2. Incorporation by Reference. (1) "Post Residency Registration", Form BPO3, 01/2013[07/2012] is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Prosthetics, Orthotics, and Pedorthics, 911 Leawood Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 5 p.m.

SIENNA NEWMAN, Chairperson
APPROVED BY AGENCY: January 3, 2013
FILED WITH LRC: January 15, 2013 at 11 a.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Monday, February 25, 2013 at 10 a.m., local time, at the Kentucky Board of Licensure for Orthotists, Prosthetists, Orthotists/Prosthetists, Pedorthists, or Orthotic Fitters, 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) workdays prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until Thursday, February 28, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Angela Evans, Board Counsel, Office of the Attorney General, 700 Capital Avenue, Suite 118, Frankfort, Kentucky 40601, phone (502) 696-5300, fax (502) 564-6801.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Angela Evans

(1) Provide a brief summary of: Establishes procedures and conditions for a person to continue practice without a license fol-
I. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? None.

II. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 319B.030(1)(c).

III. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None.

IV. (a) How much will it cost the administrative regulation (in the first year)? None.

V. How much will it cost to administer this program for subsequent years? None.

VI. Other Explanation: N/A

VOLUMES 39, NUMBER 8 – FEBRUARY 1, 2013

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

TOURISM, ARTS AND HERITAGE CABINET

Department of Fish and Wildlife Resources

(AMENDMENT)

301 KAR 2:132. Elk depredation permits, landowner cooperator permits, and quota hunts.

RELATES TO: KRS 150.010, 150.170(4), 150.180, 150.990
STATUTORY AUTHORITY: KRS 150.025(1), 150.177, 150.178, 150.390(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish and maintain permits, bag limits, and the methods of taking wildlife. KRS 150.177 authorizes the department to issue special commission permits for game species to nonprofit wildlife conservation organizations. KRS 150.178 authorizes the department to issue cooperator permits to landowners who enroll property for public hunting access. KRS 150.390(3) authorizes the department to promulgate administrative regulations establishing the conditions under which depredation permits for elk may be issued. This administrative regulation establishes the requirements for the elk permit drawing and quota hunts, the conditions under which special commission and landowner cooperator permits can be used, procedures for elk damage abatement, and any postseason hunt held after the quota hunts.

Section 1. Definitions. (1) "Antlered elk" means an elk having visible polished antler protruding above the hairline.

(2) "Antlerless elk" means an elk without visible polished antler protruding above the hairline.

(3) "At-large" means any portion of the elk zone not included in a limited entry area.

(4) "Bait" means a substance composed of grains, minerals, salt, fruits, vegetables, hay, or any other food materials, whether natural or manufactured, that may lure, entice, or attract wildlife, but shall not include the establishment and maintenance of plantings for wildlife, foods found scattered solely as the result of normal agricultural planning or harvesting practices, foods available to wildlife through normal agricultural practices of livestock feeding if

by the change if it is an amendment: This amendment does not increase fees nor is any funding necessary to implement. The amendment will allow individuals who have taken the examination from the Board of Certification/Accreditation International (BOC) to use that examination for licensure.

TIERING: Is tiering applied? No.
the areas are occupied by livestock actively consuming the feed on a daily basis, or standing farm crops under normal agricultural practices.

6) “Electronic decoy” means a motorized decoy powered by electricity, regardless of source.

7) “Elk” means Cervus elaphus nelsoni. (2) “Elk Hunting Unit or EMU” means a designated area in the restoration zone with specific management restrictions.

8) “Elk Management Unit” or “EMU” means a designated area in the restoration zone with specific management restrictions for a post-season antlerless elk quota hunt.

9) “Landowner cooperator” means a landowner or lessee who owns or leases at least 5,000 acres of land in the restoration zone and enters an agreement with the department to allow public access and hunting for at least five (5) years.

10) “Limited Entry Area” or “LEA” means a designated area in the restoration zone with specific management restrictions.

11) “Out-of-zone” means all counties not included in the restoration zone.

12) “Restoration zone” means the following Kentucky counties: Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Leslie, Letcher, Magoffin, Martin, McCrackey, Perry, Pike, and Whitley.

13) “Spike” means an elk having one (1) or two (2) antler points on each side.

14) “Youth” means a person under the age of sixteen (16) by the first date of the hunt.

Section 2. Elk Damage Control. The department may authorize the removal or destruction of elk that are causing property damage. A person authorized to destroy an elk shall:

1) Attach a department-issued disposal permit to an elk prior to moving the carcass; and

2) Not remove the disposal permit until the carcass is processed.

Section 3. Elk Quota Hunts. (1) The elk quota hunt application period shall be January 1 to April 30.

2) An applicant shall:

(a) Complete the elk quota hunt application process on the department’s Web site at fw.ky.gov; and

(b) Pay a nonrefundable application fee of ten (10) dollars per person shall apply for the elk quota hunt via the department’s Web site to apply for any quota hunt may be processed.

3) The commissioner may extend the application deadline if technical difficulties with the application system prevent applications from being accepted for one (1) or more days during the application period.

4) There shall be a random electronic drawing from each application pool.

5) Youth may enter a separate drawing pool for ten (10) either-sex elk permits that shall be valid for use during all elk seasons:

(a) Anywhere in the at large portion of the restoration zone; or

(b) Within an LEA if the youth applies for and is drawn for an LEA, pursuant to Section 5(3) of this administrative regulation.

6) A youth for (5) either-sex elk permits shall be available for a special youth-only quota hunt to be held for three (3) consecutive days beginning the last Saturday in September on Paul Van Boven WMA and adjacent private lands as allowed by the landowner.

7) A youth shall be a separate random electronic drawing for the youth-only elk quota hunt.

8) The application period for the youth-only elk quota hunt shall be December 1 through April 30.

9) A youth applicant shall not apply for the youth-only elk quota hunt more than once per application period.

10) An applicant for the youth-only elk quota hunt may also apply for the regular quota hunts as established in subsection (12) of this section.

11) A youth applicant drawn for the youth-only elk quota hunt shall not be drawn in any other elk quota held during the same calendar year.

12) A youth drawn for the youth-only elk quota hunt shall be ineligible to be drawn in the youth-only elk quota hunt in subsequent years.

13) A youth applicant drawn for the youth-only elk quota hunt shall be nonresidents.

14) No more than ten (10) percent of all drawn applicants in each quota hunt pool shall be nonresidents.

15) A quota hunt permit awarded by any department-administered lottery shall not be transferable.

16) In addition to the youth-only quota hunt, there shall be four (4) separate regular elk quota hunts established in subsection (12) of this section.

17) No be eligible to be drawn in more than one (1) of the four (4) quota hunts established in subsection (12) of this section.

18) Only be selected by a random electronic drawing; and

19) Pay a nonrefundable application fee of ten (10) dollars for each lottery entry.

20) A person who is drawn for an antlered elk quota hunt shall be ineligible to be drawn for any antlered elk quota hunt for the following three (3) years.

Section 4. Landowner Cooperator Permits. (1) With the approval of the commission, the commissioner shall issue to a landowner cooperator:

(a) One (1) either-sex permit annually per 5,000 acres of land enrolled with the department in a hunting access agreement for the duration of the agreement;

(b) Two (2) antlerless-only permits annually per 5,000 acres of land enrolled with the department in a hunting access agreement for the duration of the agreement; or

(c) One (1) antlerless-only permit annually per 5,000 acres of land enrolled with the department in an elk hunting access agreement for the duration of the agreement.

2) A recipient of a landowner cooperator permit shall comply with the season, bag limit, and hunter requirements in Sections 5 and 6 of this administrative regulation.

3) A landowner cooperator permit is transferable, but shall only be used on the land for which the agreement was made.

4) The permit may be transferred to any person eligible to hunt in Kentucky.

5) Prior to hunting, the landowner cooperator or person who has received the transferred permit shall provide the department with the hunter’s:

1. Name;
Section 5. Hunter Requirements. (1) A person shall carry proof of purchase of a valid Kentucky hunting license and valid elk permit while hunting, unless exempted by KRS 150.170.

(2) The statewide bag limit shall be one (1) elk per hunter per license year.

(3) A drawn hunter may apply to hunt in up to three (3) LEAs on the department’s Web site after the initial drawing.

(4) A hunter who does not apply for an LEA or who is not drawn for an LEA may hunt anywhere in the at-large portion of the zone.

(5) A hunter drawn for an LEA may hunt only in the assigned LEA area except that a person who is drawn for any elk quota hunt may hunt on his or her land within the restoration zone.

(6) An elk hunter in the restoration zone may be accompanied by up to two (2) other individuals.

(4) A person drawn for a regular quota hunt shall be assigned to a single EHU and shall not hunt outside that EHU, except that a drawn applicant who owns land in the elk restoration zone may hunt on his or her land.

(4) An elk hunter or any person accompanying an elk hunter shall comply with hunter orange requirements established in 301 KAR 2:172.

(7) An elk hunter shall not:

(a) Take elk except during daylight hours;

(b) Use dogs, except to recover wounded elk using leashed tracking dogs;

(c) Hunt over bait inside the elk restoration zone;

(d) Drive elk from outside the assigned area[EHU];

(e) Take an elk while it is swimming;

(f) Use electronic calls or electronic decoys; or

(g) Take an elk if the hunter is in a vehicle, boat, or on horseback, except that a disabled hunter who has a hunting method exemption permit issued pursuant to 301 KAR 3:027, by the department may use a stationary vehicle as a hunting platform.

(8)[4] A person shall:

(a) Obtain a vehicle tag from the department prior to hunting elk in the restoration zone; and

(b) Display the vehicle tag in the windshield of the vehicle while hunting elk.

(9) A person under sixteen (16) years old shall be accompanied by an adult who shall remain in a position to take immediate control of the person’s firearm.

(10)[9] An adult accompanying a person under sixteen (16) years old shall not be required to possess a hunting license or elk permit if the adult is not hunting.

(11)[10] A hunter may use any deer hunting method authorized by 301 KAR 2:172.

(12)[11] A person shall not use any of the following items to take an elk:

(a) Any weapon or device prohibited for deer hunting pursuant to 301 KAR 2:172;

(b) A modern firearm less than .270 caliber;

(c) A muzzle-loading firearm less than .50 caliber;

(d) A shotgun less than 20 gauge;

(e) Any arrow without a broadhead point;

(f) A handgun with a barrel length of less than six (6) inches, a bore diameter less than .270 inches (.270 caliber), and when fired, the bullet shall produce at least 550 ft/lbs of energy at 100 yards.

(13)[12] A quota elk hunter shall only take an elk of the type and sex determined by the permit drawn.

(14)[13] An individual who receives or is transferred a license, permit, or special commission permit to hunt in all of the antlered-only or antlerless-only quota hunts in accordance with the seasons and limits established in Section 6 of this administrative regulation.

Section 6. Elk Quota Hunt Seasons and Limits. (1) A person drawn for an antlered or antlerless archery and crossbow permit shall not hunt when an elk firearms season is open.

(2) A person drawn for an antlered archery and crossbow permit shall use:

(a) Archery equipment to take an antlered elk beginning the third Saturday in September through the third Monday in January; and

(b) A crossbow to take an antlered elk:

1. For two (2) consecutive days beginning the third Saturday in October; and

2. From the second Saturday in November through December 31.

(3) A person drawn for an antlerless archery and crossbow permit shall use:

(a) Archery equipment to take an antlerless elk beginning the third Saturday in October through the third Monday in January; and

(b) A crossbow to take an antlerless elk:

1. For two (2) consecutive days beginning the third Saturday in October; and

2. From the second Saturday in November through December 31.

(4) A person drawn for an antlerless firearms permit shall use a modern gun or muzzleloader to take an antlered elk during one (1) of the following two (2) seven (7) day periods randomly assigned by the department:

(a) From the first Saturday in October for seven (7) consecutive days; or

(b) From the second Saturday in October for seven (7) consecutive days.

(5) A person drawn for an antlerless firearms permit shall use a modern gun or muzzleloader to take an antlerless elk during one (1) of the following two (2) seven (7) periods randomly assigned by the department:

(a) From the second Saturday in December for seven (7) consecutive days; or

(b) From the third Saturday in December for seven (7) consecutive days.

Section 7. LEA boundaries. (1) Caney LEA – Starting at the intersection of State Hwy 550 and Kentucky 1697, the boundary proceeds north on State Hwy 550 through Mousie and Betty to the intersection with State Hwy 7 near Lackey. The boundary then goes south on State Hwy 7, past Dema to intersection with State Hwy 899. The boundary then goes south on State Hwy 899, through Pippa Passes to intersection with Kentucky 1697 at Alice Lloyd College. The boundary then goes west on Kentucky 1697 to intersection with State Hwy 550 in Garnet, completing the boundary.

(2) Hazard LEA – Starting at the intersection of State Hwy 476 and State Hwy 80, the boundary proceeds east on Hwy 80 to the intersection with State Hwy 3209. The boundary then goes west on Hwy 3209 to the intersection with State Hwy 1087. The boundary then goes east on Hwy 1087 to the intersection with State Hwy 1098 near Yellow Mountain. The boundary then follows Hwy 1098 north and west to the intersection with State Hwy 15 near Quicksand. The boundary then goes south on Hwy 15 to the intersection with State Hwy 476 near Lost Creek. The boundary then goes south on Hwy 476 to the intersection with State Highway 80, completing the boundary.

(3) Straight Creek LEA – Starting at the intersection of State Hwy 66 and State Hwy 221 at Straight Creek, the boundary proceeds east on Hwy 221 through Stoney Fork to the intersection with US Route 421 at Bledsoe. The boundary then proceeds north following US Route 421 to the intersection with State Hwy 2058 at Helton. The boundary then follows Hwy 2058 west to the intersection with State Hwy 1780 near Spruce Pine. The boundary then follows on Hwy 1780 north to the intersection with State Hwy 1850 at Warbranch. The boundary then follows Hwy 1850 west to the intersection with State Highway 66. The boundary then follows Hwy 66 south to the intersection with Hwy 221 to complete the boundary.[EHU boundaries. (1) EHU 1 – Starting at the Martin/Lawrence County line at the Tug Fork of the Big Sandy River, the boundary proceeds southeast following the Tug Fork to the Pike County/Buchanan County, Virginia line. The boundary then
proceeds southwest following the Kentucky/Virginia state line to U.S. Hwy 23. The boundary proceeds north following U.S. Hwy 23 to the Johnson/Lawrence County line. The boundary proceeds east following the county line of Johnson/Lawrence and Marshall/Warren Counties. The boundary then follows State Hwy 23, the boundary proceeds south to the intersection of U.S. Hwy 23 with State Hwy 80. The boundary then follows State Hwy 80 west to the intersection with State Hwy 15. The boundary then follows north following State Hwy 15 to the intersection of State Hwy 15 with the Breathitt/Wolfe County line. The boundary then follows the county lines of Magoffin/Wolfe County, Magoffin/Morgan County, and Johnson/Morgan County northeast to U.S. Hwy 23, completing the boundary.

(2) EHU 2 - Starting at the Johnson/Lawrence County line on U.S. Hwy 23, the boundary proceeds south to the intersection of U.S. Hwy 23 with State Hwy 80. The boundary then follows State Hwy 80 west to the intersection with State Hwy 15. The boundary then follows north following State Hwy 15 to the intersection of State Hwy 15 with the Breathitt/Wolfe County line. The boundary then follows the county lines of Magoffin/Wolfe County, Magoffin/Morgan County, and Johnson/Morgan County northeast to U.S. Hwy 23, completing the boundary.

(3) EHU 2A - Starting at the intersection of U.S. Hwy 23 and State Hwy 80, the boundary proceeds south following U.S. Hwy 23 to the intersection of U.S. Hwy 23 with the Kentucky/Virginia state line. The boundary then follows U.S. Hwy 119 west to the intersection of U.S. Hwy 119 with State Hwy 15. The boundary then follows State Hwy 15 northwest to the intersection of State Hwy 15 with State Hwy 80. The boundary then follows State Hwy 80 northeast to the intersection of State Hwy 80 and U.S. Hwy 23, completing the boundary.

(4) EHU 4 - Starting at the intersection of State Hwy 550 and Kentucky 1697, go north on State Hwy 550 through Mousie and Belcher to the intersection with State Hwy 221. The boundary then follows State Hwy 221 west to the intersection of State Hwy 221 and State Hwy 899. Turn south on State Hwy 899, go through Pippa Passes to the intersection with Kentucky 1697 at Alice Lloyd College. Go west on Kentucky 1697 to the intersection with State Hwy 550 in Garnet, completing the boundary.

(5) EHU 4A - Starting at the intersection of the Hal Rogers Parkway and State Hwy 15, the boundary proceeds south following State Hwy 15 to the intersection of State Hwy 15 and Hal Rogers Parkway. The boundary then follows Hal Rogers Parkway west to the Clay/Laurel County line. The boundary then follows the county lines of Clay/Jackson County, Clay/Owsley County, Perry/Owsley County, Breathitt/Owsley County, Breathitt/Lee County, and Breathitt/Wolfe County northeast to State Hwy 15 at the Breathitt/Wolfe County line, completing the boundary.

(6) EHU 5A - Starting at the south line of the Hal Rogers Parkway and State Hwy 15, the boundary proceeds south following State Hwy 15 to the intersection of State Hwy 15 and U.S. Hwy 119. The boundary then follows U.S. Hwy 119 east to the intersection of U.S. Hwy 119 and U.S. Hwy 23. The boundary then follows U.S. Hwy 23 south to the intersection of U.S. Hwy 23 with the Kentucky/Virginia state line. The boundary then follows the Kentucky/Virginia state line to the intersection of Kentucky 1767 and Kentucky 2011. The boundary then follows State Hwy 66 north to the intersection with Kentucky 2011 near Beverly, the boundary proceeds south along State Hwy 66 to the intersection with State Hwy 221. The boundary then proceeds north on State Hwy 66 to the intersection with Kentucky 2058 near Spruce Pine, then proceeds south on State Hwy 221 at Straight Creek, turning north along State Hwy 66 to the intersection with Kentucky 66 near Queendale. The boundary then follows State Hwy 66 north to the intersection with Hal Rogers Parkway at Big Creek, completing the boundary.

Section 8. Post-season Quota Hunt[er(s)] on Private Land.

(1) A modern firearms quota hunt for antlerless elk and spikes shall take place beginning on the fourth Saturday in January for fourteen (14) consecutive days.

(2) Each hunter shall be randomly drawn from the pool of applicants:

(a) Who were not drawn for the previous elk quota hunts; and

(b) Who are residents of the elk restoration zone.

(3) A drawn applicant shall comply with the requirements in Section 5 of this administrative regulation except that an applicant may hunt only in the assigned EMU or on land the applicant owns within another EMU.

(4) EMU boundaries shall be:

(a) Knott County EMU - Starting at the intersection of State Hwy 550 and State Hwy 7 near Lackey, the boundary proceeds south along State Hwy 7 to the intersection with State Hwy 582 then north along State Hwy 582 to the intersection with State Hwy 66 at Stoney Fork. The boundary then follows north on State Hwy 66 to the intersection with State Hwy 550 at Hindman, turning north-east on State Hwy 550 to the intersection with State Hwy 7, thus completing the boundary.

(b) Stoney Fork EMU - Starting at the intersection of State Hwy 2058 and U.S. Hwy 421 near Helton, the boundary then proceeds south along U.S. Hwy 421 to the intersection of U.S. Hwy 421 and U.S. Hwy 119 near Harlan, then west along U.S. Hwy 119 to the intersection of U.S. Hwy 119 and U.S. Hwy 25E. The boundary then goes north following U.S. Hwy 25E to the intersection with State Hwy 66, then north on State Hwy 66 to the intersection of State Hwys 66 and 1850, then east along State Hwy 1850 to the intersection of State Hwys 1850 and 1780 at Warbranch. The boundary then proceeds south on State Hwy 1780 to its intersection with State Hwy 2058 near Spruce Pine, then east on State Hwy 2058 back to U.S. Hwy 421 at Helton, thus completing the boundary.

(5) Any public hunting area within an EMU shall be closed to elk hunting during this season.

Section 9. Tagging and Checking Requirements. (1) Immediately after taking an elk and prior to removing the head from the carcass, a hunter shall:

[a](I) Record on a hunter's log the following information:

1: [a] The species harvested;

2: [a] The sex of the animal;
Section 10. Elk Hunting on Public Land. (1) A person drawn for an elk quota hunt or the recipient of a special commission permit may hunt on Wildlife Management Areas (WMA), Hunter Access Areas, state forests, the Big South Fork National River and Recreation Area, the Daniel Boone National Forest, and the Jefferson National Forest within the restoration zone under the conditions of the permit received.

(2) Portions of Paintsville Lake WMA that lie out of the restoration zone are subject to the requirements established in Section 11 of this administrative regulation.

(3) Elk hunting shall not be allowed on public areas during quota deer hunts listed in 301 KAR 2:178.

(4) Paul Van Booven WMA.

(a) The archery and crossbow seasons shall be open as established in Section 6 of this administrative regulation.

(b) Firearms shall not be used to hunt elk. [Firearms shall not be used to hunt elk, except that youth participating in the youth-only elk quota hunt may use any deer hunting method authorized by 301 KAR 2:172 to take elk.]

(c) The WMA shall be closed to all other hunting during the youth-only elk quota hunt.

(5) A person shall not mimic the sound of an elk on public land open to elk hunting from September 1 until the opening of the elk archery season.

Section 11. Out-of-zone Elk Hunting. (1) The methods for taking deer and the deer seasons established in 301 KAR 2:172 shall apply to a person taking elk outside of the restoration zone, except that a hunter shall not use any of the following to take elk:

(a) Any weapon or device prohibited for deer hunting pursuant to 301 KAR 2:172;

(b) A modern firearm less than .270 caliber;

(c) A muzzle-loading firearm less than .50 caliber;

(d) A shotgun less than twenty (20) gauge;

(e) Any arrow without a broadhead point; or

(f) A handgun:

1. With a barrel length of less than six (6) inches;

2. With a bore diameter of less than .270 caliber; and

3. That produces less than 550 foot-pounds of energy at 100 yards.

(2) Unless exempted by KRS 150.170, a person who is hunting out-of-zone elk shall possess:

(a) A valid Kentucky hunting license; and

(b) An out-of-zone elk permit.

(3) A person may take an elk of either sex, which shall not count toward the person's deer bag limit.

(4) Any elk harvested out-of-zone shall be telechecked pursuant to Section 9 of this administrative regulation.

Section 12. A person who takes possession of any elk antler that has the skull or skull plate attached to it shall contact the department’s Law Enforcement Division within twenty-four (24) hours to obtain a disposal permit.

Section 13. A person who is the recipient of a valid elk quota hunt permit, landowner cooperating permit, or special commission permit may defer use of the permit to the following year if:

(1) There is a death of the permit holder’s:

(a) Spouse;

(b) Child; or

(c) Legal guardian, if the permit holder is under eighteen (18) years old; and

(2) The permit holder provides to the department a death certificate and one (1) of the following documents prior to May 1 of the year following the hunting season:

(a) A marriage certificate;

(b) A birth certificate; or

(c) An affidavit of paternity or maternity.

BENJY T. KINMAN, Deputy Commissioner
For DR. JONATHAN GASSETT, Commissioner
MARCHETA SPARROW, Secretary
APPROVED BY AGENCY: January 10, 2013
FILED WITH LRC: January 11, 2013 at 3 p.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2013, at 10 a.m. at the Department of Fish and Wildlife Resources in the Commission Room of the Arnold L. Mitchell Building, #1 Sportsman’s Lane, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by five business days prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation by February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: ROSE Mack, Department of Fish and Wildlife Resources, Arnold L. Mitchell Building, #1 Sportsman’s Lane, Frankfort, Kentucky 40601, phone (502) 564-3400, fax (502) 564-9136, email fwpubliccomments@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Rose Mack

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes elk hunting requirements and legal methods to handle elk depredation problems.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to define the boundaries of the areas and units to which hunters are assigned, to establish hunting procedures, and to effectively manage elk in Kentucky.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish hunting seasons, bag limits, and the methods of taking wildlife. KRS 150.177 authorizes the department to issue special commission permits for game species to nonprofit wildlife conservation organizations. KRS 150.178 authorizes the department to issue depredation permits for elk depredation permits for elk may be issued.

2. If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This amendment moves the opening of the elk quota hunt application period to January 1 instead of December 1, replaces the elk hunting unit (EHU) system with a limited entry area
and zone-at-large system, replaces the five (5) permit, Paul Van Booven WMA youth-only hunt with ten (10) youth permits valid for the at-large zone for the entire season, removes the restriction on the number of assistants who can be afield with an elk hunter, removes the ten dark restriction on permits on PVB WMA, and clarifies that elk may be harvested over bait outside of the elk zone consistent with the deer hunting requirements of 301 KAR 2:172.

(b) The necessity of the amendment to this administrative regulation: See 1 (b) above.

(c) How the amendment conforms to the content of the authorizing statutes: See 1(c) above.

(d) How the amendment will assist in the effective administration of the statute: See 1(d) above.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are approximately 35,000 to 60,000 people who apply to hunt elk in Kentucky each year. People who own or lease land over 5,000 acres can enter into an agreement with the Department for public hunting access and receive elk tags. Property owners sustaining damage from elk can benefit from the late season depredation hunt. Residents of the elk zone who applied for the regular season hunt are also eligible for the late season depredation hunt.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) The actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Persons wishing to apply for the next season’s elk hunt may apply starting January 1. A person drawn for the quota hunts may elect to apply for a limited entry area or hunt anywhere within the zone at large with permission of the landowner. Youth interested in applying for the ten (10) special youth tags will continue to apply via the department’s website.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This amendment does not change any costs to the entities identified in 3.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Hunters who do not wish to hunt in limited entry area or who are not drawn to hunt an limited entry area will no longer be restricted to one (1) of eleven (11) elk hunting units but rather may hunt anywhere in the elk zone not part of an limited entry area. Youth who apply for the special hunt will now be able to hunt the at-large zone during all seasons rather than a special three (3) day hunt limited to one (1) WMA area. Drawn hunters will no longer be limited to just five assistants.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: Other than a minor administrative cost, there will be no additional cost to the agency to implement this administrative regulation.

(b) On a continuing basis: There will be no additional cost to the agency on a continuing basis.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding is the State Game and Fish Fund. The department already has the mechanisms in place for administering quota hunt application procedures, random drawings and other aspects of the elk hunts.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Additional fees for direct implementation of this regulation are not necessary, as infrastructure for conducting all aspects of elk management and quota hunts already exists (see 6 above).

(8) State whether or not this administrative regulation establishes new fees or directly or indirectly increased any fees: This administrative regulation amendment does not establish any fees nor does it indirectly increase any fees.

(9) TIERING: Is tiering applied? Yes. Residents of the elk restoration zone who are not drawn for the regular quota hunt shall be eligible for a late season depredation hunt. The purpose of this hunt is to allow residents to assist landowners in removing elk causing property damage in two (2) areas with chronic nuisance elk problems. Fewer than fifty (50) tags for antlerless and spike bulls will be drawn. These tags can only be used on private land within one of the two (2) Elk Management Units (EMUs). The number of tags to be issued will be determined by the level of nuisance elk cases or property damage caused by elk documented within the EMUs prior to January each year.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Department of Fish and Wildlife Resources’ Divisions of Wildlife and Law Enforcement will be impacted by this amendment.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 150.025, KRS 150.177, KRS 150.178, KRS 150.390.

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? There will be no additional costs for the first year. The Department already has mechanisms in place for quota hunt application procedures, random drawings and other aspects of the elk hunts.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? Each year has brought increases in the number of applicants and thus the direct revenue to KDFWR. There is also a positive economic impact to cities, counties and local businesses in and near the elk restoration zone, but the specific dollar amount is unknown.

(c) How much will it cost to administer this program for the first year? There will be no additional costs for the first year. The Department already has mechanisms in place for quota hunt application procedures, random drawings and other aspects of the elk hunts.

(d) How much will it cost to administer this program for subsequent years? There will be no additional costs incurred for subsequent years. The Department already has the mechanisms in place for administering quota hunt application procedures, random drawings and other aspects of the elk hunts.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/–):
Expenditures (+/–):
Other Explanation:

TOURISM, ARTS AND HERITAGE CABINET
Department of Fish and Wildlife Resources
(Amendment)

301 KAR 2:178. Deer hunting on Wildlife Management Areas, state parks, other public lands, and federally controlled areas.

RELATES TO: KRS 150.010, 150.170, 150.340, 150.370(1), 150.390, 150.390(1), 150.620
STATUTORY AUTHORITY: 148.029(5), 150.025(1), 150.390(1), 150.620
NECESSITY, FUNCTION, AND CONFORMITY: KRS 148.029(5) authorizes the Department of Parks, in cooperation with the Department of Fish and Wildlife Resources, to implement wildlife management plans on state parks. KRS 150.025(1) authorizes...
the department to promulgate administrative regulations to establish open seasons for the taking of wildlife, to regulate bag limits, and to make these requirements apply to a limited area. KRS 150.390(1) prohibits the taking of deer in any manner contrary to any provisions of KRS Chapter 150 or its administrative regulations. KRS 150.620 authorizes the department to promulgate administrative regulations for the maintenance and operation of the lands it has acquired for public recreation. This administrative regulation establishes deer hunting seasons, application procedures, and other matters pertaining to deer hunting on Wildlife Management Areas, state parks, other public lands, and federally controlled areas that differ from statewide requirements.

Section 1. Definitions. (1) “Bait” means a substance composed of grains, minerals, salt, fruits, vegetables, hay, or any other food materials, whether natural or manufactured, that may lure, entice, or attract wildlife.

(2) “Centerfire” means a type of firearm that detonates a cartridge by the firing pin striking a primer in the middle of the end of the cartridge casing.

(3) “In-line muzzleloading gun” means a firearm capable of being loaded only from the discharging end of the barrel or cylinder, that is also equipped with an enclosed ignition system located directly behind the powder charge.

(4) “Mobility-impaired” means an individual who meets the requirements of Section 2(1) of 301 KAR 3:026.

(5) “Modern firearm season” means the ten (10) or sixteen (16) consecutive day period beginning the second Saturday in November when bleeching-loading firearms may be used to take deer pursuant to 301 KAR 2:172.

(6) “Optical enhancement” means any sighting device other than open or fixed sights.

(7) “Quota hunt” means a “Wildlife Management Area or state park” hunt where a participant is selected by a random drawing.

(8) “Statewide requirements” mean statewide season dates, zone descriptions, and other requirements for deer hunting established in 301 KAR 2:172.

Section 2. General WMA Requirements. (1) Unless specified in this administrative regulation, statewide requirements shall apply to a WMA.

(2) A hunter shall not take more than one (1) deer per day on a WMA in Zones 2, 3, or 4, except:

(a) During a quota hunt; or

(b) The Grayson Lake WMA open youth deer hunt.

(3) Unless specified in Section 6 of this administrative regulation, if a WMA is in two (2) or more deer hunting zones as established in 301 KAR 2:172, then the WMA shall be regulated by the most liberal zone requirements of the zones in which it lies.

(4) Deer hunting on WMAs listed in Section 6 of this administrative regulation[] shall be permitted only as stated, except archery hunting is allowed under the statewide archery requirements established in 301 KAR 2:172, unless otherwise noted.

(5) An open firearm deer hunt, beginning on the Wednesday following the third Monday in January for ten (10) consecutive days, shall:

(a) Be limited to members of the United States Armed Forces and the National Guard and reserve component who:

1. Are residents of Kentucky or nonresidents stationed in Kentucky; and

2. Were deployed out-of-country during any portion of the most recent regular statewide deer season.

(b) Only be on a WMA designated as open for this special hunt; and

(c) Follow statewide requirements established in 301 KAR 2:172.

(6) On all WMA’s and Otter Creek Outdoor Recreation Area, a person:

(a) Shall not use a nail, spike, screw-in device, wire, or tree climber for attaching a tree stand or climbing a tree;

(b) May use a portable stand or climbing device that does not injure a tree;

(c) Shall not place a portable stand in a tree more than two (2) weeks before opening day, and shall remove it within one (1) week following the last day, of each hunting period;

(d) Shall plainly mark the portable stand with the hunter’s name and address;

(e) Shall not use an existing permanent tree stand; and

(f) Shall not place, distribute, or hunt over bait.

(7) A person without a valid quota hunt confirmation number shall not enter a WMA during a quota hunt on that area except:

(a) To travel through a WMA on an established road or to use an area designated open by a sign; or

(b) One (1) assistant, who shall not be required to have applied for the quota hunt, may accompany a mobility-impaired hunter who was drawn to hunt.

(8) Except for waterfowl or dove hunting, or legal hunting at night, a person who is hunting any species or a person who is accompanying a hunter, shall wear hunter orange clothing pursuant to 301 KAR 2:172 while:

(a) On a WMA when firearms deer hunting is allowed; and

(b) Hunting within the sixteen (16) county elk zone when a firearms elk season is open, pursuant to 301 KAR 2:132; or

(c) Hunting within the bear zone during a bear firearms season, pursuant to 301 KAR 2:300.

Section 3. General Quota Hunt Procedures. (1) A quota hunt applicant who is not selected and applies to hunt the following year shall be given one (1) preference point for each year the applicant was not selected.

(2) If selected for a quota hunt[other than the Taylorsville Lake WMA antlerless-only hunt], a person shall lose all accumulated preference points.

(3) A random selection of hunters with preference points shall be made for each year’s quota hunts before those without preference points are chosen.

(4) A person shall forfeit all accumulated preference points if, in a given year, they do not apply for or are ineligible to apply for:

(a) A deer quota hunt; and

(b) The no-hunt option.

(5) A person who applies for the no-hunt option shall:

(a) Not be drawn for a quota hunt; and

(b) Be given one (1) preference point for each year the no-hunt option is selected.

(6) If applying as a party:

(a) Each applicant’s preference points are independent of each other; and

(b) The entire party is selected if one (1) member of the party is selected.

(7) The commission may extend the application deadline if technical difficulties with the automated application system prevent applications from being accepted for one (1) or more days during the application period.

(8) A hunter may take up to two (2) deer on a quota hunt in Zones 2, 3, and 4, only one (1) of which may be an antlered deer, except as authorized in Section 6 of this administrative regulation.

(9) Provided a person has purchased the appropriate permits, a hunter may take unlimited antlerless deer in:

(a) The West Kentucky WMA firearms season;

(b) WMA quota hunts in Zone 1; and

(c) State Park quota hunts in Zone 1, except as specified in section 7 of this administrative regulation.

(10) One (1) person shall be drawn from the eligible quota hunt applicants who were not selected in the original drawing, and shall receive one (1) deer permit that carries with it all the privileges of the Special Commission Permit described in 301 KAR 3:100.

Section 4. Quota Hunt Application Process. A person applying for a quota hunt shall:

(1) Call the toll free number listed in the current fall hunting and
Section 5. Quota Hunt Participant Requirements. Except as otherwise specified in this administrative regulation, a person selected to participate in a quota hunt shall:

1. Except if exempted by KRS 150.170, possess:
   (a) A valid annual Kentucky hunting license; and
   (b) A deer permit that authorizes the taking of deer with the equipment being used and in accordance with the zone restrictions where the hunt will occur;

2. Possess an annual Kentucky hunting license, except as provided in KRS 150.170(3) and 150.170(6);

3. Possess an additional deer permit if the person does not want a harvested antlerless deer to apply toward the statewide bag limit, pursuant to 301 KAR 2:172;

4. Not be required to possess a deer permit if the person:
   (a) Is under twelve (12) years old;
   (b) Possesses and presents a senior/disabled combination hunting and fishing license at check-in; or
   (c) Is under twenty-one (21) years old and in assigned areas selected by a random drawing of applicants if applicable;

5. Hunt on the assigned dates and in assigned areas selected by a random drawing of applicants if applicable;

6. Comply with hunting equipment restrictions specified by the type of hunt;

7. Check in at the designated check station prior to hunting;

   (a) Either:
      1. On the day before the hunt, between noon and 8 p.m. local time; or
      2. On the day of the hunt, between 5:30 a.m. and 8 p.m. Eastern time; and
   (b) With documentation of the participant’s:
      1. Social Security number or driver confirmation number; and
      2. Purchase of a current statewide deer permit;

7. Check out at the designated check station:
   (a) If finished hunting;
   (b) If the hunter’s bag limit is reached; or
   (c) By 8 p.m. Eastern time on the final day of the hunt;

8. Take a harvested deer to the designated check station by 8 p.m. Eastern time the day the deer was harvested.

9. Be declared ineligible to apply for the next year’s drawing if the hunter fails to check out properly; and

10. Comply with all species quota hunt requirements, including the fifteen (15) inch minimum outside antler spread harvest restriction for antlered deer when in effect, or to be ineligible to apply for any quota hunt or no-hunt option until specified requirements are met.

11. The crossbow, modern firearm, muzzleloader seasons shall be open under statewide requirements, except archery hunting shall be prohibited during the quota hunt.

12. A hunter shall not take a deer with antlers having an outside spread of less than fifteen (15) inches.

13. Not be eligible to apply for the next year’s draw for two (2) consecutive days beginning on the first Saturday in November.

14. Not apply as a group of more than five (5) persons; and

15. Not apply for any quota hunt or no quota hunt requirements, including the fifteen (15) inch minimum outside antler spread harvest restriction for antlered deer when in effect, or to be ineligible to apply for any quota hunt for these species the following year.
(12)[(43)] Grayson Lake WMA.
(a) An open youth hunt shall:
1. Be the first Saturday in November for two (2) consecutive days.
2. Have a two (2) deer bag limit, only one (1) of which may be an antlered deer; and
3. Have additional[bonus] deer permits apply.
(b) A person who has not checked in shall not enter the Grayson Lake WMA during the open youth hunt, except to:
1. Travel through the WMA on an established public road; or
2. Use an area designated as open by signs.
(c) The property of Camp Webb shall be open for a mobility-impaired deer hunting event during the first weekend of October as established in 301 KAR 3:110.
(d) The crossbow hunt shall be from the first Saturday in September through the third Monday in January, except during the November open youth hunt.
(e) The statewide youth firearm season shall be open under statewide requirements.
(13)[(44)] Green River Lake WMA and Dennis-Gray WMA.
(a) The crossbow season shall be open under statewide requirements.
(b) The quota hunt shall be for two (2) consecutive days beginning the first Saturday in November.
(c) Fifteen (15) openings shall be reserved in the quota hunt for mobility-impaired persons.
(d) A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.
(e) The Green River Lake and Dennis-Gray WMAs shall be considered to be located in the Eastern Time Zone.
(14)[(45)] Griffith Woods WMA. The crossbow and youth firearm seasons shall be open under statewide requirements.
(15)[(46)] Higginson-Henry WMA.
(a) The youth firearm deer season shall be open under statewide requirements.
(b) A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.
(c) A hunter shall not take more than one (1) deer from the WMA per license year.
(16)[(47)] J.C. Williams WMA. The crossbow season shall be open under statewide requirements.
(17)[(48)] Kentucky River WMA. The crossbow and youth firearm seasons shall be open under statewide requirements.
(18)[(49)] Kleber WMA.
(a) The crossbow season shall be open under statewide requirements, except during a quota hunt.
(b) The quota hunts shall be for:
1. Two (2) consecutive days beginning the first Saturday in November; and
2. Two (2) consecutive days beginning the first Saturday in December.
(c) The youth firearm season shall be open under statewide requirements.
(19)[(50)] Knobs State Forest WMA. The crossbow season shall be open under statewide requirements except:
(a) The North Refuge is closed from November 1 to February 15; and
(b) Duck Island is closed from October 15 to March 15.
(20)[(51)] Lewis County WMA.
(a) The modern firearm and youth firearm seasons shall be open under statewide requirements, except the use of centerfire rifles and handguns shall be prohibited.
(b) The crossbow and muzzleloader seasons shall be open under statewide requirements.
(21)[(52)] Livingston County WMA. The crossbow, youth firearm, muzzleloader, and modern firearm seasons shall be open under statewide requirements, except a person shall not hunt deer with a modern gun during the modern firearm deer season.
(22)[(53)] Curtis Gates Lloyd WMA. The crossbow season shall be open under statewide requirements.
(23)[(54)] Marion County WMA.
(a) The crossbow, muzzleloader, and youth firearm seasons shall be open under statewide requirements.
(b) There shall be a quota hunt for:
1. Five (5) consecutive days beginning the second Saturday in November; and
2. Five (5) consecutive days beginning the Thursday following the second Saturday in November.
(c) A quota hunt participant shall not be required to check in and out of the WMA, but shall telecheck or internet-check harvested deer as specified in 301 KAR 2:172.
(24)[(55)] Mill Creek WMA.
(a) The crossbow season shall be open under statewide requirements.
(b) The quota hunt shall:
1. Be for two (2) consecutive days beginning the first Saturday in November; and
2. Have a one (1) deer bag limit.
(25)[(56)] Miller-Welch Central Kentucky WMA. The archery and crossbow seasons shall be open under statewide requirements.
(26)[(57)] Mill Creek WMA.
(a) The crossbow season shall be open under statewide requirements.
(b) The quota hunt shall:
1. Be for two (2) consecutive days beginning the first Saturday in November; and
2. Have a one (1) deer bag limit.
(27)[(58)] Mud Camp Creek WMA. The crossbow, youth firearm, and muzzleloader seasons shall be open under statewide requirements.
(28)[(59)] Mullins WMA. The crossbow season shall be open under statewide requirements.
(29)[(60)] Ohio River Islands WMA, Stewart Island Unit.
(a) The muzzleloader season shall be for two (2) consecutive days beginning the third Saturday in October.
(b) The archery season shall be from the first Saturday in September through October 14.
(c) The crossbow season shall be from October 1 through October 14.
(d) The October youth season shall be open under statewide requirements.
(e) The remainder of the WMA shall be open under statewide requirements.
(30)[(61)] Paintsville Lake WMA.
(a) The quota hunt shall be for two (2) consecutive days beginning the first Saturday in November.
(b) The crossbow and youth firearm seasons shall be open under statewide requirements.
(c) A person shall not use firearms for deer hunting on:
1. The area extending eastward from the drainage of Glade Branch, along the north edge of the lake, to the No Hunting Area surrounding Rocky Knob Recreation Area and enclosing all property from the WMA boundary downslope to the lake edge; and
2. The islands to the south and that portion of the area extending eastward along the south edge of the lake from the drainage of Shoal Branch to the No Hunting Area surrounding the dam and ranger station, and extending downslope to the edge of the lake.
(d) A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.
(31)[(62)] Peabody WMA.
(a) The crossbow, youth firearms, and muzzleloader seasons shall be open under statewide requirements.
(b) The modern firearm season shall be open under statewide requirements for ten (10) consecutive days beginning the second Saturday in November.
(32)[(63)] Perryville State Forest-Tradewater WMA.
(a) The crossbow season shall be open under statewide requirements.
(b) The quota hunt shall be for two (2) consecutive days beginning the first Saturday in November.
(c) A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.
(33)[(64)] Pioneer Weapons WMA. Statewide requirements shall apply except that a person:
(a) Shall not use a modern firearm;
(b) Shall not use an in-line muzzleloading gun;
(c) Shall not use a scope [or optical enhancement; and]
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(d) May use a crossbow during the entire archery season; and
(e) Shall use only open or iron sights on any weapon.

(34) Redbird WMA. The crossbow season shall be open under statewide requirements.

(35) Dr. James R. Rich WMA.
(a) The crossbow season shall be open under statewide requirements, except during a quota hunt.
(b) The quota hunts shall be for:
   1. Two (2) consecutive days beginning the first Saturday in November; and
   2. Two (2) consecutive days beginning the first Saturday in December; and
(c) The youth firearm season shall be open under statewide requirements.

(36) Robinson Forest WMA.
(a) A person shall not hunt deer on the main block of Robinson Forest.
(b) The remainder of the WMA shall be open under statewide requirements.

(37) Sloughs WMA.
(a) On the Sauerheber Unit, the archery, crossbow, muzzleloader, and youth firearm seasons shall be open under statewide requirements through October 31, except that the Crenshaw and Duncan II Tracts shall be open under statewide requirements through the end of modern firearm season.
(b) The remainder of the WMA shall be open under statewide requirements.

(38) South Shore WMA.
(a) The youth firearm, October muzzleloader, and modern firearm seasons shall be open under statewide requirements through November 14, except that the use of centerfire rifles and handguns shall be prohibited.
(b) The archery and crossbow seasons shall be open under statewide requirements, except the area shall be closed November 15 through January 15.
(39) T.N. Sullivan WMA. The crossbow season shall be open under statewide requirements.

(40) R.F. Tarter WMA. The crossbow, youth firearm, and muzzleloader seasons shall be open under statewide requirements.

(41) Taylorsville Lake WMA.
(a) There shall be a quota hunt for:
   1. Two (2) consecutive days beginning the first Saturday in November for antlerless deer;
   2. Two (2) consecutive days beginning the first Saturday in December; and
   3. Two (2) consecutive days beginning the first Saturday in January.
(b) Seven (7) openings shall be reserved in each quota hunt for mobility-impaired persons.
(c) The youth firearm season shall be open under statewide requirements.
(d) The crossbow season shall be open under statewide requirements.

(e) A quota hunt participant shall be given one (1) preference point for each female deer checked in, up to four. [Applicant drawn for the antlerless-only quota hunt shall not lose any accumulated preference points.]

(42) Twin Eagle WMA. The crossbow season shall be open under statewide requirements.

(43) Paul Van Booven WMA. The area shall be open under statewide requirements, except that:
(a) The area shall be closed to vehicle access from an hour after sunset to an hour before sunrise, except that a hunter may retrieve downed game.
(b) The crossbow, muzzleloader, and youth firearm seasons shall be open under statewide requirements.
(c) There shall be a quota hunt for:
   1. Five (5) consecutive days beginning the second Saturday in November; and
   2. Five (5) consecutive days beginning the Thursday following the second Saturday in November.
(d) The bag limit for a quota hunt shall be one (1) deer.
(e) A quota hunt participant shall not be required to check in and out of the WMA, but shall check in a harvested deer pursuant to 301 KAR 2:172.

(43) a) A hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.

(44) Veteran's Memorial WMA.
(a) The crossbow and youth firearm seasons shall be open under statewide requirements.
(b) There shall be a quota hunt for two (2) consecutive days beginning the first Saturday in November.

(45) West Kentucky WMA.
(a) All tracts shall be open under statewide requirements for the archery and crossbow seasons, except that all tracts shall be closed to archery and crossbow hunting during department administered quota and firearm deer hunts.
(b) Tracts 1-6 shall be open to shotgun and muzzleloader hunters participating in the quota and open firearm deer hunts.
(c) Tract 7 and “A” Tracts shall not be open for department administered quota or firearm deer hunts.
(d) The quota hunt shall be for five (5) consecutive days beginning the Saturday prior to Thanksgiving.
(e) The firearms season shall:
   1. Be for three (3) consecutive days beginning the Saturday preceding the third Monday in January;
   2. Be limited to the first 200 hunters;
   3. Require a hunter to check-in at a designated check station from 4 p.m. to 8 p.m. Central Time on the day before the hunt or between 4:30 a.m. and 7 p.m. Central Time on hunt days;
   4. Shall require a hunter to check out at the designated check station.
   a. When finished hunting; or
   b. By 7 p.m. Central time on the final day of the hunt.
   5. Have an unlimited bag limit, only one (1) of which may be an antlered deer;
   6. Have additional deer permits apply; and
   7. Require every person to check in during the firearms season quota hunt, except for:
      a. A person traveling on an established public road; or
      b. A person in an area designated as open by signs.
   f) Firearm hunters shall not use centerfire rifles or handguns;
   g) All persons shall check in daily at the designated check-in locations before entering the “A” tracts.
   h) A deer hunter shall not take a deer with antlers that have an outside spread of less than fifteen (15) inches.
      i) A hunter shall:
         1. Sign in for the hunting tract of his or her choice at check-in prior to each day’s hunt; and
         2. Except after noon, not hunt outside of that tract.

(46) Yatesville WMA. The crossbow, youth firearm, muzzleloader, and modern firearm seasons shall be open under statewide requirements, except a person shall not take antlerless deer with a firearm during the modern firearm deer season.

(47) Yellowbank WMA.
(a) The crossbow and youth firearm seasons shall be open under statewide requirements.
(b) A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.

Section 7. State Park Deer Seasons. (1) A state park may allow archery and crossbow hunting from the first Saturday in September through the third Monday in January for antlered or antlerless deer.
(2) A state park may allow up to sixteen (16) days of firearm hunting and up to eleven (11) days of muzzleloader hunting from the first Saturday in September through the third Monday in January for antlered or antlerless deer.
(3) The following state parks shall be open to deer hunting as specified below and according to requirements in Section 8 of this administrative regulation:
(a) Lake Barkley State Resort Park. Deer hunting shall be permitted on the first[second] Tuesday of January for two (2) consecutive days.
(b) Greenbo Lake State Resort Park. Deer hunting shall be permitted on the first[second] Tuesday of January for two (2) consecutive days.
(c) Green River Lake State Park.
1. Archery and crossbow deer hunting shall be permitted be-
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beginning the second Thursday of December for four (4) consecutive days.
2. Archery and crossbow deer hunting shall be permitted beginning the third Thursday of December for four (4) consecutive days.
3. A deer hunter shall not take an antlered deer with antlers having an outside spread of less than fifteen (15) inches.
4. A deer hunter shall not take an antlered deer with antlers having an outside spread of less than fifteen (15) inches.
5. A deer hunter shall not take an antlered deer with antlers having an outside spread of less than fifteen (15) inches.

Section 8. State Park Deer Hunt Requirements. (1) Except for the open hunts at Jenny Wiley State Resort Park and Yatesville Lake State Park, a person shall not hunt on a state park unless:
(a) Selected by a random drawing as described in Section 3 of this administrative regulation;
(b) The person is a member of a successful applicant’s hunting party; or
(c) The person was selected as part of a process administered by the Department of Parks, pursuant to Section 7 of this administrative regulation.
(2) A person participating in a state park hunt, except for the quota hunts at Green River Lake State Park and the Yatesville Lake State Park open deer hunt, shall:
(a) Check in and check out as required in Section 5 of this administrative regulation;
(b) Furnish at check-in a driver’s license or other form of government-issued identification; and
(c) Check in:
   1. Between noon and 8 p.m. Eastern Time the day before the hunt at the state park campground if hunting in the Yatesville Lake State Park open deer hunt; or
   2. At the park the day before the hunt if hunting in the Jenny Wiley State Resort Park deer hunt; and
   3. Not be eligible to apply for a quota hunt the following year if the person does not check out as required in Section 5 of this administrative regulation.
(3) A person participating in a state park deer hunt shall:
(a) Comply with the provisions of 301 KAR 2:172; and
(b) Check harvested deer daily at the designated park check station, except that deer taken in the Green River Lake State Park quota hunts and the open hunts at Jenny Wiley State Resort Park and Yatesville Lake State Park shall be telechecked or checked in on the department’s website at fw.ky.gov, pursuant to 301 KAR 2:172.
(4) A person participating in a state park deer hunt shall not:
(a) Take more than two (2) deer in a quota hunt, only one (1) of which may be antlered;
(b) Hunt over bait;
(c) Injure a tree by using:
   1. A tree stand except a portable stand;
   2. Climbing devices that nail or screw to the tree; or
   3. Climbing spikes;
(d) Leave a deer stand unattended for more than twenty-four (24) hours;
(e) Discharge a firearm within 100 yards of a maintained road or building; and
(f) Hunt:
   1. In an area posted as closed by signs; or
   2. Outside park boundaries.
(5) A person participating in a state park deer hunt, other than the open hunts at Jenny Wiley State Resort Park and Yatesville Lake State Park and any department administered state park quota hunt, may take up to two (2) bonus deer per hunt that shall not count toward the statewide limit if the person:
(a) Takes no more than one (1) bonus antlered deer per license year; and
(b) Obtains the valid bonus deer tag(s) from the state park hunt administrators.

Section 9. Other Public Lands. (1) On Daniel Boone National Forest, Jefferson National Forest, and Land Between the Lakes, a person shall not use bait, feed, minerals, or other attractants.
(2) The following areas may schedule a firearm, crossbow, or archery deer hunting season between September 1 and January 31:
(a) Big South Fork National River and Recreation Area;
(b) Clark’s River National Wildlife Refuge;
(c) Daniel Boone National Forest;
(d) Jefferson National Forest;
(e) Land Between the Lakes National Recreation Area;
(f) Ohio River Islands National Wildlife Refuge; and
(g) Reelfoot National Wildlife Refuge.
(3) An area listed in subsection (2) of this section may issue a bonus permit for antlered or antlerless deer which shall:
(a) Not count against a hunter’s statewide bag limit; and
(b) Only be issued for a hunt that is open to the general public.
(4) At Land Between the Lakes, a person:
(a) Shall not take more than:
   1. Two (2) deer during archery hunts; and
   2. One (1) deer during quota hunts.
(b) Who is a quota deer hunter shall:
   1. Apply in advance at Land Between the Lakes; and
   2. Only hunt from one-half (1/2) hour before sunrise until one-half (1/2) hour after sunset.
(c) A person who harvests a deer shall:
   1. Check in the carcass pursuant to U.S. Forest Service requirements.
   2. Affix a game check card pursuant to U.S. Forest Service requirements.
   3. Apply in advance at Land Between the Lakes; and
   4. Only be issued for a hunt that is open to the general public.
(5) At Reelfoot National Wildlife Refuge:
(a) Zone 1 bag limits apply during the open archery season;
(b) A person shall not take more than two (2) deer by firearm, only one (1) of which shall be antlered;
(c) A quota hunt participant shall:
   1. Tag deer with a tag issued by the Refuge; and
   2. Comply with the Refuge check-in requirements; and
   3. A person who is archery hunting shall:
      1. Only take deer using the appropriate statewide or additional deer permit; and
      2. Check harvested deer through the department’s telephone or online check-in systems.
(6) At Otter Creek Outdoor Recreation Area:
(a) The archery and crossbow seasons shall be open under statewide requirements; and
(b) There shall be a quota hunt for:
   1. Two (2) consecutive days beginning the third Saturday in November; and
   2. Two (2) consecutive days beginning the second Saturday in December.
(7) At Twin Knobs Campground, the area shall be closed to all statewide seasons, except that there shall be a quota hunt on the second Saturday in December during even-numbered years for mobility-impaired persons.
(8) At Ziplo Campground, the area shall be closed to all statewide seasons, except that there shall be a quota hunt on the second Saturday in December during odd-numbered years for mobility-impaired persons.

Section 10. Special Areas under Federal Control. (1) The following areas may schedule a firearm, archery, or crossbow deer hunting season between September 1 and January 31:
(a) Bluegrass Army Depot;
(b) Fort Campbell;
(c) Fort Knox;
(d) Hidden Valley Training Center; and
(e) Wendell Ford Regional Training Center.
(2) An area listed in subsection (1) of this section may issue a bonus permit for antlered or antlerless deer which shall:
(a) Not count against a hunter’s statewide bag limit; and
(b) Only be issued for a hunt that is open to the general public.
(3) Except on the Hidden Valley Training area, on the areas listed in subsection (1) of this section, a deer hunter shall:
(a) Obtain a permit from the area before hunting;
(b) Only hunt on assigned dates;
(c) Remain in assigned areas;
(d) Tag deer with tags issued on the area, unless otherwise specified in this section;
(e) Keep the area tag attached to the deer until the carcass is processed; and
(f) Check deer at a designated check station before leaving the area.
(4) At Bluegrass Army Depot, a person shall not take an antlered deer whose outside antler spread is less than fifteen (15) inches.
(5) At Fort Knox, a person shall not take an antlered deer whose outside antler spread is less than twelve (12) inches.
(6) At Hidden Valley Training Area, a person shall not use a firearm to hunt deer.

BENJY KINMAN, Deputy Commissioner
For, DR. JONATHAN GASSETT, Commissioner
MARCHETA SPARROW, Secretary
APPROVED BY AGENCY: January 10, 2013
FILED WITH LRC: January 11, 2013 at 3 p.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2013, at 11 a.m. at the Department of Fish and Wildlife Resources in the Commission Room of the Arnold L. Mitchell Building, #1 Sportsman’s Lane, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing five business days prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation by February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Rose Mack, Department of Fish and Wildlife Resources, Arnold L. Mitchell Building, #1 Sportsman’s Lane, Frankfort, Kentucky 40601, phone (502) 564-7109, ext. 4507, fax (502) 564-9136, email lwpu@ky.gov

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT
Contact Person: Rose Mack
(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the deer hunting seasons, limits, and equipment restrictions under which deer may be taken on wildlife management areas, state parks, and other lands controlled by state or federal government agencies.
(b) The necessity of this administrative regulation: To establish deer hunting seasons, limits, and methods of taking deer to control and manage deer populations and hunting pressure on wildlife management areas, state parks, and other public lands.
(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 150.025 authorizes the Department of Fish and Wildlife Resources to promulgate administrative regulations governing hunting seasons, including deer. KRS 150.390(1) prohibits the taking of deer in any manner contrary to any provisions of KRS Chapter 150 or its administrative regulations. KRS 150.620 authorizes the department to manage public lands for hunting and fishing.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the administration of the statute by establishing guidelines for effectively managing deer herds on Wildlife Management Areas (WMAs) and state parks, including the establishment of guidelines to ensure safe, orderly hunting practices on public lands.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment modifies the deer hunting requirements and restrictions for ten (10) areas and removes one area not open to public hunting.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to maximize hunter opportunity without harm to the deer resource.
(c) How the amendment conforms to the content of the authorizing statutes: See (1)(c) above.
(3) How the amendment will assist in the effective administration of the statutes: See (1)(d) above.
(4) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Persons who wish to deer hunt on WMAs or state parks in Kentucky will be affected. In 2011, there were 9,097 total quota hunt applications for 4,054 available slots.
(5) Provide an analysis of how the entities identified in question (3) will have to take to comply with this administrative regulation (if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Those who hunt deer on WMAs and state parks must comply with the individual hunt requirements for those sites, as listed in the fall hunting guide produced by the department.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There should be no direct cost to hunters as a result of this amendment to the administrative regulation.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Deer hunters will benefit from increased hunting opportunity on several public lands.
(6) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
(a) Initially: There will be no additional cost to the agency to implement this administrative regulation.
(b) On a continuing basis: There will be no additional cost on a continuing basis.
(7) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding is the State Game and Fish Fund.
(8) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: It will not be necessary to increase a fee or funding to implement this administrative regulation.
(9) TIERING: Is tiering applied? Tiering was not used because all persons who hunt deer on WMAs or state parks are required to abide by these guidelines.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT
(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Department of Fish and Wildlife Resources’ Wildlife and Law Enforcement Divisions will be affected by this administrative regulation.
(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 148.029, 150.025, 150.390 and 150.620.
(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? No revenue will be generated for the first year.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? No revenue will be generated in subsequent years.

(c) How much will it cost to administer this program for the first year? There will be no additional costs to administer this program for the first year.

(d) How much will it cost to administer this program for subsequent years? There will no additional costs to administer this program in subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/–):
Expenditures (+/–):
Other Explanation:

TOURISM, ARTS AND HERITAGE CABINET
Kentucky Department of Fish and Wildlife Resources
(Amendment)

301 KAR 2:195. Falconry, raptor take, and raptor propagation [Raptor-propagation and falconry].

RELATES TO: KRS 150.010, [150.025], 150.180, 150.183, 150.280, 150.305, 150.320, 150.330, 150.360[50 C.F.R. Parts 13, 17, 21, 22]

STATUTORY AUTHORITY: KRS 150.025(1), 150.280(1), [150.025, 150.028], 50 C.F.R. Parts 13, 17, 21, 22

NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations establishing procedures for propagating and holding of protected wildlife, 50 C.F.R. Parts 13, 17, 21, and 22 establish requirements for permitting, taking, possessing, and selling of raptors and endangered and threatened species. This administrative regulation establishes permitting, taking, possessing, and reporting requirements for people engaged in falconry and raptor propagation.

Section 1. Definitions. (1) "Adult raptor" means a raptor that is at least one (1) year old.

(2) "Captive-bred raptor" means a raptor or the eggs thereof, hatched in captivity from parents in captivity.

(3) "Eyas" means a young raptor that is still in the nest and not capable of flight.

(4) "Hack" means the temporary release of a raptor held for falconry to the wild so that it can survive on its own.

(5) "Hybrid raptor" means an offspring produced by two (2) distinct raptor species.

(6) "Imprinted" means a raptor that has been hand-raised by a human in isolation from the sight of other raptors from two (2) weeks of age through fledging.

(7) "Native raptor" means a raptor species which has historically existed or currently exists in the wild in Kentucky without introduction by humans.

(8) "Passage bird" means a raptor less than one (1) year of age that is capable of sustained flight and is no longer dependent on parental care.

(9) "Wild raptor" means a raptor that was originally taken from the wild.

Section 2. Federal requirements. Except as established in Sections 3 through 11 of this administrative regulation, a person shall be in compliance with the federal requirements established in 50 C.F.R. Part:

(a) 13;
(b) 17;
(c) 21; and
(d) 22.

Section 3. Permits and Licenses. (1) A person shall be required to obtain and possess a falconry permit to take or possess a raptor for use in falconry.

(a) A person with a valid state or federal falconry permit;

(b) May take wildlife pursuant to applicable statewide requirements if the falconer:

1. Has a valid Kentucky hunting license; or
2. Is hunting license exempt pursuant to KRS 150.170; and
3. Shall not be required to obtain a wildlife transportation permit pursuant to 301 KAR 2:081 and 2:082 if the person:

(a) Is importing or transporting a legally held falconry raptor into Kentucky; or
(b) Is transporting a legally held falconry raptor into and through Kentucky to a destination outside of Kentucky.

Section 4. Falconry Permit Requirements, Classes of Permits, and Apprentice Sponsors. (1) To obtain a falconry permit of any class, a person shall:

(a) Complete a Kentucky Falconry Permit Application form provided by the Department; and
(b) Submit to the department:

1. The completed application;
2. The appropriate fee as established in 301 KAR 3:022; and
3. A completed Raptor Facilities and Equipment Inspection Report form signed by a state conservation officer.

(2) An apprentice falconry permit applicant shall:

(a) Be at least twelve (12) years old;
(b) Obtain a sponsor who holds a Kentucky general or master falconry permit pursuant to subsection (10) of this section;
(c) If under eighteen (18) years old, have a parent or legal guardian co-sign the application;
(d) Contact the department to schedule a time to take a written examination administered by the department; and
(e) Pass the written examination by scoring a minimum of eighty (80) percent.

(3) An apprentice class falconry permit holder shall:

(a) Only possess one (1) of the following wild or captive-bred raptors at any given time:

1. American kestrel (Falco sparverius);
2. Red-tailed hawk (Buteo jamaicensis);
3. Red-shouldered hawk (Buteo lineatus); or
4. Harris’ hawk (Parabuteo unicinctus); and
(b) Not possess a raptor:

1. Taken from the wild as a nestling; or
2. That is imprinted on humans;

(4) A general class falconry permit applicant shall:

(a) Be at least sixteen (16) years old;
(b) If under eighteen (18) years old, have a parent or legal guardian co-sign the application;
(c) Have practiced falconry at the apprentice level for at least two (2) years; and
(d) Have complied with all previous year reporting requirements, if applicable, pursuant to Section 7 of this administrative regulation.

(5) A first time general class permit applicant shall also submit to the department a:

(a) Signed document from a general or master class falconry permit holder stating that the permit applicant has:

1. Practiced falconry with a wild raptor at the apprentice level for at least two (2) years; and
2. Maintained, trained, and hunted with a raptor for an average of six (6) months per year with at least four (4) months in each year;

(b) Summary of the species held as an apprentice; and
(c) The length of time the apprentice held each bird.

(6) A general class falconry permit holder shall:

(7) A Hybrid raptor means an offspring produced by two (2) distinct raptor species.
(a) Be allowed to possess the following:
   1. A raptor obtained from the wild;
   2. A hybrid raptor;
   3. A captive-bred raptor; and
   (b) Not possess more than three (3) of the following raptors at any given time:
      1. Great horned owl (Bubo virginianus); or
      2. Any member of the Order Falconiformes, except for the following species which shall not be possessed:
         a. Golden eagle (Aquila chrysaetos);
         b. Bald eagle (Haliaeetus leucocephalus);
         c. White-tailed eagle (Haliaeetus albicilla); or
         d. Stellar’s sea eagle (Haliaeetus pelagicus).

(7) A master class falconry permit applicant shall:
   (a) Have held a general class falconry permit for at least five (5) years; and
   (b) Have complied with all previous year reporting requirements, pursuant to Section 7 of this administrative regulation.

(8) A first time master class permit applicant shall submit to the department a signed letter attesting that the applicant has practiced falconry at the general class permit level for at least five (5) years.

(9) A master class falconry permit holder:
   (a) Shall not possess more than five (5) of the following wild raptors at any given time:
      1. Great horned owl; and
      2. Any member of the Order Falconiformes except a bald eagle;
   (b) Shall obtain prior approval from the department pursuant to the requirements of 50 C.F.R. 21 and 22 to possess any of the following raptors:
      1. Golden eagle;
      2. White-tailed eagle; or
      3. Stellar’s sea eagle; and
   (c) May possess any number of captive-bred raptors of the species allowed in paragraph (a) and (b) of this subsection.

(10) An apprentice permit shall:
   (a) Not have more than three (3) apprentices at any given time;
   (b) Be at least eighteen (18) years old;
   (c) Possess a valid Kentucky general or master class falconry permit; and
   (d) Have held a general class falconry permit for a minimum of two (2) years; and
   (e) Submit a signed letter to the department:
      1. Attesting that the sponsor will assist the apprentice in:
         a. Learning about the husbandry and training of raptors held for falconry;
         b. Learning relevant wildlife laws and regulations; and
         c. Deciding which species of raptor is most appropriate for the apprentice to possess; and
      2. Containing the sponsor’s:
         a. Name;
         b. Falconry permit number;
         c. Address; and
         d. Telephone number.

(11) A sponsor who is withdrawing sponsorship of an apprentice shall:
   (a) Notify the department in writing within five (5) days of withdrawing the sponsorship; and
   (b) Provide the apprentice with a signed and dated document stating the length of time that the apprentice practiced falconry under the sponsor’s guidance.

(12) An apprentice who loses sponsorship shall obtain a new sponsor within thirty (30) days from the sponsor’s notification of withdrawal.

(13) A new sponsor shall be in compliance with the requirements established in subsection (7) of this section.

(14) If an apprentice fails to obtain a new sponsor within thirty (30) days, the department shall:
   (a) Revoke the apprentice’s falconry permit; and
   (b) Confiscate any raptor in the apprentice’s possession if the apprentice does not transfer ownership of the raptor to another licensed falconer.

(15) A non-resident falconer who moves to Kentucky to estab-
tucky hunting license when taking a raptor from the wild.

(2) When taking a raptor from the wild, a nonresident shall have in possession:
(a) A valid Kentucky nonresident hunting license;
(b) A valid falconry permit or equivalent from the nonresident's home state; and
(c) An approved Kentucky Nonresident Raptor Take Form.

(3) To obtain a Kentucky Nonresident Raptor Take Form, a person shall:
(a) Print a copy of the form from the department's Web site at fw.ky.gov; or
(b) Contact the department at 800-858-1549 and request a mailed copy.

(4) A person shall submit to the department a completed and signed Kentucky Nonresident Raptor Take Form at least fifteen (15) working days prior to the requested take date.

(5) A falconry permit holder shall be responsible for complying with all applicable federal requirements if taking raptors on federal land.

(6) A falconry permit holder who is a nonresident shall only take one (1) legal raptor in Kentucky per calendar year.

(7) An approved Kentucky Nonresident Raptor Take Form shall only be issued to a person whose state of residence allows a Kentucky resident to legally take a raptor from that state.

(8) A nonresident falconer who takes a raptor in Kentucky shall submit a complete and signed Falconry Take Location Report within five (5) days of taking a bird.

(9) A licensed falconer shall comply with all raptor take requirements established in 50 C.F.R. 21 in addition to the requirements established in this section.

(10) A resident falconry permit holder shall not take more than two (2) raptors from the wild in any calendar year.

(11) An eyas shall only be taken:
(a) By a general or master class falconry permit holder; and
(b) From January 1 through July 31.

(12) A person shall not take more than one (1) sharp-shinned hawk (Accipiter striatus) eyas per calendar year.

(13) There shall be an annual maximum quota for sharp-shinned hawk eyases of:
(a) Ten (10) for Kentucky residents; and
(b) Five (5) for nonresidents.

(14) Prior to taking a sharp-shinned hawk eyas, a person shall be responsible for calling the department at 800-858-1549 to check if the sharp-shinned hawk eyas annual quota has been reached.

(15) A person shall not take a sharp-shinned hawk eyas from a nest unless there are at least three (3) eyases in the nest.

(16) Each person who takes a sharp-shinned hawk eyas shall submit to the department the Falconry Take Location Report within five (5) days of possession.

(17) Any permit class falconer may take a passage bird if it is a species the falconer is allowed to possess as established in Section 4 of this administrative regulation.

(18) The allowable period of take for:
(a) A passage bird, other than a great horned owl, is September 1 through January 31;
(b) An adult or passage bird great horned owl is September 1 through October 31; and
(c) An adult American kestrel shall only be taken from September 1 through January 31.

(19) An adult American kestrel or adult great horned owl shall only be taken by a:
(a) General class permit holder; or
(b) Master class permit holder.

(20) A person shall not take a peregrine falcon (Falco perigruis) from the wild in Kentucky.

(21) A person shall not release the following raptors into the wild:
(a) A non-native raptor;
(b) A hybrid raptor; or
(c) A captive-bred, native raptor.

(22) Prior to releasing a raptor into the wild, a person shall remove all leg bands from the bird.

(23) A falconry permit holder shall complete and submit to the department a federal form 3-186A or enter the required information in the federal database at http://permits.fws.gov/186A within five (5) days if a raptor is:
(a) Acquired;
(b) Transferred;
(c) Released;
(d) Lost;
(e) Reband;
(f) Microchipped;
(g) Stolen; or
(h) Dead.

(24) A falconer shall retain copies of each submitted 3-186A form or electronically submitted data for a minimum of five (5) years following a raptor's:
(a) Transfer;
(b) Release;
(c) Loss; or
(d) Death.

Section 8. Transfer of Ownership and Propagation. (1) A falconry permit holder may transfer ownership of a wild-caught raptor pursuant to 50 C.F.R. Part 21, but shall not engage in the following activities with wild-caught raptors:
(a) Selling;
(b) Purchasing;
(c) Trading; or
(d) Bartering.

(2) A falconry permit holder who is in compliance with the requirements established in this section if:
(a) A nonresident falconer who takes a raptor in Kentucky simultaneously takes a Falconry Take Location Report.
(b) A nonresident falconer who takes a raptor in Kentucky is a state resident of the state in which the raptor was taken and submits a Falconry Take Location Report.
(c) A nonresident falconer who takes a raptor in Kentucky simultaneously takes a Falconry Take Location Report.
(d) A nonresident falconer who takes a raptor in Kentucky simultaneously takes a Falconry Take Location Report.

Section 9. Other Activities. (1) A falconry permit holder may use a raptor for conservation education programs, pursuant to 50 C.F.R. Part 21.

(2) A falconry permit holder who is in compliance with the requirements for Special Purpose Abatement, pursuant to 50 C.F.R. Part 21, may receive payment for nuisance wildlife control activity if the permit holder also possesses a Kentucky Commercial Nuisance Wildlife Control permit, pursuant to 301 KAR 3:120.

(3) A person may assist a permitted wildlife rehabilitator, as established in 301 KAR 2:075, in conditioning raptors for subsequent release into the wild if the person is:
(a) A general or master class falconry permit holder; and
(b) Working with a species the falconry permit holder is allowed
to possess.
(4) A general or master class permit holder may hack a raptor
if the permit holder contacts the department and provides the fol-
lowing information:
(a) The hack site location;
(b) The species of raptor;
(c) The origin of the raptor; and
(d) The planned hacking dates.

Section 10. Revocation of Permits and Appeal Procedure. (1)
The department shall revoke the falconry permit of a person con-
victed of a violation of this administrative regulation for a period of
one (1) year.
(2) A person may request an administrative hearing pursuant
to KRS Chapter 138 if the person’s falconry permit is:
(a) Denied; or
(b) Revoked.

Section 11. Incorporation by Reference. (1) The following ma-
terial is incorporated by reference:
(a) “Kentucky Falconry Permit Application”, January 2013 edi-
tion;
(b) “Raptor Facilities and Equipment Inspection Report”, Janu-
ary 2013 edition;
(c) “Falconry Take Location Report”, January 2013 edition; and
(d) “Kentucky Nonresident Raptor Take Form”, January 2013 edi-
tion.
(2) This material may be inspected, copied, or obtained, sub-
ject to applicable copyright law, at the Department of Fish and
Wildlife Resources, #1 Sportsman’s Lane, Frankfort, Kentucky
40601, Monday through Friday, 8 a.m. to 4:30 p.m. Eastern
Time (KRS 150.025 authorizes the department to promulgate ad-
ministrative regulations governing the taking of wildlife. 50 C.F.R.
Parts 13, 17, 21, and 22 authorize the protection of endangered
species and birds of prey. This administrative regulation establish-
es the requirements for the propagation of raptors and for falconry.

Section 1. Definitions. (1) “Exotic raptor” means those species
which have no subspecies occurring in the wild in the United
States or Mexico and which require the holding of a joint state and
federal falconry permit to lawfully possess.
(2) “Legal hunting raptor” means the great horned owl (Bubo
virginianus) and all hawks and falcons of the families Falconidae and
Accipitridae, except those that are endangered or threatened and
under conditions described in Section 4(1)(c) of this adminis-
trative regulation. golden eagles (Aquila chrysaetos) as well as
threatened species.

Section 2. Except as provided by Sections 3 through 11 of this
administrative regulation, C.F.R. Part 13, General Permit Proce-
dures; Part 17, Subpart 17.11, Endangered and Threatened Wild-
life; Part 21, Migratory Bird Permits; and Part 22, Eagle Permits
shall apply to the propagation of raptors and falconry.

Section 3. Hunting License, Falconry Permit Requirements and
Transportation Permit Waiver. (1) Wildlife may be taken within
state hunting seasons and bag limits with any legal hunting raptor
provided the falconer has a valid state or federal falconry permit
and a valid Kentucky resident or nonresident hunting license in his
or her possession.
(2) A licensed falconer may undertake intrastate transportation
of any legally held raptor without possessing a transportation per-
mit as required in 301 KAR 2:081 and 2:082.

Section 4. Classes of Falconry Permits- Sponsors, Application,
Processing and Issuance, Examination Required, Duration of Per-
mits, and Exotic and Nonexotic Class of falconry permits.
(a) Apprentice falconry permits.
1. An apprentice falconer shall be at least fourteen (14) years of
age and shall have a sponsor holding a general or master falconry
permit.
2. An applicant between the ages of fourteen (14) and sixteen (16)
years shall provide a written consent form or letter from a parent or
guardian.
3. An apprentice may take and possess only one (1) nonexotic
raptor, which shall be taken from the wild, and shall not take more
than two (2) replacements from the wild during any twelve (12)
month period which begins when the first replacement raptor is
taken from the wild.
4. Only an American kestrel (Falco sparverius), red-tailed hawk
(Buteo jamaicensis), red-shouldered hawk (Buteo lineatus), or any
exotic legal hunting raptor may be possessed or taken by an ap-
prentice falconer.
5. The red-tailed and red-shouldered hawks shall be first-year
(passage) age class birds, capable of flight.
6. An American kestrel which has left the nest and is capable of
flight may be taken from the wild.
7. There shall be no age restriction on exotic raptors.
8. An apprentice falconer may buy and sell only exotic raptors.
(b) General falconry permits.
1. General permit holder shall:
(a) At least eighteen (18) years of age; and
(b) Have at least two (2) years experience in the practice of falcony
at the apprentice level; and
c. Have complied with all reporting requirements of this adminis-
trative regulation.
2. A permittee at the general level may possess no more than two (2)
nonexotic raptors and shall not take more than two (2) re-
placements from the wild during any twelve (12) month period
which begins when any replacement raptor is taken from the wild.
3. A general permittee may take and possess any legal hunting
raptor defined in this administrative regulation.
(c) Master falconry permits.
1. A master permittee shall have at least five (5) years experience
in the practice of falconry at the general class level and have com-
plied with all requirements of this administrative regulation.
2. A master permittee may possess no more than three (3) non-
exotic raptors.
3. No more than two (2) replacements for replacement birds shall be
taken from the wild during any twelve (12) month period which
begins when any replacement raptor is taken from the wild.
4. A master permittee may take and possess any legal hunting
raptor, but shall not take in any twelve (12) month period, as part
of the three (3) bird limitation, more than one (1) raptor listed as
threatened in 50 C.F.R. Part 17, Subpart B, Section 17.11, and
then only when approved by the U.S. Fish and Wildlife Service and
the Department of Fish and Wildlife Resources.
5. A master falconer may replace any number of captive bred rap-
tors a year if the possession limit at one (1) time is not exceeded.
6. The permit has been issued by the department and in accord-
ance with the Bald Eagle Protection Act and 50 C.F.R. Part 22,
Subpart B, Section 22.24; a master permittee may take and pos-
sess golden eagles for falconry purposes.
7. A master permittee shall not take any species listed as endan-
gered by 50 C.F.R. Part 17, Subpart B, Section 17.11, but may
possess those species in accordance with the Endangered Spe-
cies Act and implementing regulations.
(d) Sponsorship.
1. A sponsor shall hold a master or general falconry permit.
2. A sponsor shall not have more than three (3) apprentices at
any one (1) time.
3. A sponsor withdrawing sponsorship shall notify the depart-
ment in writing giving reasons for withdrawal and shall notify the ap-
prentice.
4. If the apprentice does not have a new sponsor within thirty
(30) days from the date of notification of withdrawal, his or her
permit shall be deemed cancelled and the birds relocated.
5. Application, processing and issuance.
(a) In order to obtain any class of joint state/federal falconry
permit, an applicant shall complete the standard falconry permit
application form (KXY-1), incorporated by reference in Section 12
of this administrative regulation, as designated by the Department
of Fish and Wildlife Resources and approved by the U.S. Fish and
Wildlife Service.
(b) Accompanying the completed application shall be two (2)
checks:
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1. One (1) payable to the Department of Fish and Wildlife Resources in the amount specified for a falconry permit in 301 KAR 3:022; and
2. One (1) payable to the U.S. Fish and Wildlife Service in the amount specified in 50 C.F.R. Part 13, Subpart B, Section 13.11.
(c) Also accompanying the application shall be an inventory of raptors which the applicant possesses at the time of application as specified in Section 6(1) of this administrative regulation and 50 C.F.R. Part 21, Subpart C, Section 21.28.
(d) Upon receipt of a completed application, inventory and fees, the application shall be forwarded to the appropriate state conservation officer who shall administer the required examination and inspect equipment and facilities.
(a) If the equipment and facilities are found to be adequate and the applicant passes the examination as specified in subsection (4) of this section, the state conservation officer shall certify that by affixing his signature on a letter of recommendation, and the Department of Fish and Wildlife Resources shall forward the application, certification, appropriate fee and test score to the U.S. Fish and Wildlife Service.
2. The U.S. Fish and Wildlife Service may then issue the permit according to the applicable terms and conditions of 50 C.F.R. Parts 13, 21, or 22.
(4) Examination required.
(a) An applicant for any class of falconry permit shall take an appropriate written examination and score no less than eighty (80) percent.
(b) The test shall be approved in accordance with 50 C.F.R. Subpart C, Part 21.29(f) and shall be administered and supervised by the Department of Fish and Wildlife Resources at a designated site.
(5) Duration of permit. A permit shall be valid for a period of three (3) years from date of issuance.
(6) Fees. Falconry permit fees are as listed in 301 KAR 3:022.

Section 5. Facilities and Equipment. (1) Facilities and equipment shall meet the minimum standards described in 50 C.F.R. Part 21, Subpart C, Section 21.29.
(2) Facilities, equipment and raptors shall be made available at all times for inspection by authorized personnel of the Department of Fish and Wildlife Resources and the U.S. Fish and Wildlife Service.

Section 6. Marking. Any peregrine falcon (Falco peregrinus), gyrfalcons (Falco rusticolus) and Harris hawks (Parabuteo unicinctus) shall be banded with markers supplied by the U.S. Fish and Wildlife Service at the time of capture, and retransmitted by the Department of Fish and Wildlife Resources at the same time.
(1) License requirements.
(a) Any permittee who buys from, sells to or barter with any person in the United States or a foreign country shall meet the conditions specified in 50 C.F.R. Part 21, Subpart C, Section 21.28.
(b) Conditions for taking raptors from the wild.
(1) Transportation of raptors. A(holder of a valid falconry permit may transport any raptors from the wild as required in 50 C.F.R. Part 21, Subpart C, Sections 21.28 and 21.30 with a copy of the report being sent to the Department of Fish and Wildlife Resources at the same time.

Section 8. Raptors Acquired Before 1977. (1) A person possessing a raptor legally acquired before January 1, 1977, who fails to meet the permit requirements, shall be allowed to retain the raptor with a nonhunting raptor permit.
(b) These raptors shall not be replaced nor used for hunting.
(c) Facilities and equipment for holding them shall meet the standards in Section 5 of this administrative regulation.
(2) A falconry permittee legally possessing raptors acquired before January 1, 1977, shall have a commercial captive wildlife permit issued by the Department of Fish and Wildlife Resources as required in 301 KAR 2:081 and 2:082.
(4) Temporary relocation of raptors.
(a) A falconry permittee legally possessing raptors acquired before January 1, 1977, shall have a commercial captive wildlife permit issued by the Department of Fish and Wildlife Resources as required in 301 KAR 2:081 and 2:082.
(b) A falconry permittee legally possessing raptors acquired before January 1, 1977, and possessing a raptor legally acquired under his class permit, shall be allowed to retain and hunt the extra raptors. Replacement of those raptors shall not occur, nor shall an additional nonexotic raptor be obtained, until the number in possession is at least one (1) less than the total number authorized by the class of permit held by the permittee.
Section 10. Release of Raptors. (1) A person shall not intentionally release to the wild any species not native to Kentucky without obtaining written permission from the commissioner. (2) The marker from the released bird shall be removed and surrendered to the department. (3) The marker from an intentionally released indigenous bird shall also be removed and surrendered to the department. (4) A federal bird band shall be affixed to a captive bred raptor intentionally released to the wild.

Section 11. Raptor Propagation Requirements, Authorized Activities, Applications, Records, and Reports. (1) Raptor propagation requirements. (a) A person shall not breed or propagate raptors without obtaining the appropriate Kentucky captive wildlife permit as required in 301 KAR 2:081. (b) A commercial captive wildlife permit authorizes the propagation and sale of raptors. (c) A noncommercial permit authorizes only propagation. (d) A permit shall comply with all requirements, including permit application, of 50 C.F.R. Part 21. Subpart C, Section 21.30. (2) Authorized activities. All activities permitted by 50 C.F.R. Part 21, Subpart C, Section 21.30 are authorized in Kentucky except as otherwise provided in this administrative regulation. (3) Applications, records, and reports. A copy of all raptor propagation applications, records, and reports required by the U.S. Fish and Wildlife Service in 50 C.F.R. Part 21, Subpart C, Section 21.30, shall be submitted to the Department of Fish and Wildlife Resources on the same date as required by 50 C.F.R. Part 21, Subpart C, Section 21.30.

Section 12. Incorporation by Reference. (1) Standard falconry permit application form (KYE-1). (12/6/06) is incorporated by reference. (2) This material may be inspected, copied, or obtained, subject to applicable copyright laws, at the Kentucky Department of Fish and Wildlife, #1, Sportsman’s Lane, Frankfort, Kentucky 40601, Monday through Friday, 8:00 am to 4:30 pm.

BENJY KINNAN, Deputy Commissioner
For DR. JONATHAN GASSETT, Commissioner
MARCHETA SPARROW, Secretary
APPROVED BY AGENCY: December 5, 2012
FILED WITH LRC: December 28, 2012 at 8 a.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2013, at 9 a.m. at the Department of Fish and Wildlife Resources in the Commission Room of the Arnold L. Mitchell Building, #1 Sportsman’s Lane, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by five business days prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation by February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Rose Mack, Department of Fish and Wildlife Resources, Arnold L. Mitchell Building, #1 Sportsman’s Lane, Frankfort, Kentucky 40601, phone (502) 564-3400, fax (502) 564-9136, email lwpubliccomments@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Rose Mack
(1) Provide a brief summary of:
(a) What the administrative regulation does: This administrative regulation establishes permitting, taking, possessing, and reporting requirements for people engaged in falconry and raptor propagation.
(b) The necessity of the administrative regulation: This administrative regulation is necessary to manage and conserve raptors and to provide reasonable opportunities for sport and recreation. This regulation is also necessary to comply with federal regulation requirements.
(c) How does this administrative regulation conform to the authorizing statutes: KRS 150.025(1) authorizes the department to promulgate administrative regulations establishing open seasons for the taking of wildlife, bag limits, and methods of taking wildlife, and to make these requirements apply to a limited area. KRS 150.280(1) requires the department to promulgate administrative regulations establishing procedures for propagating and holding of protected wildlife. 50 C.F.R. Parts 13, 17, 21, and 22 establish requirements for permitting, taking, possessing, and selling of raptors and endangered and threatened species.
(d) How will this administrative regulation assist in the effective administration of the statutes: By establishing guidelines on raptor propagation and falconry, this administrative regulation ensures the protection of birds of prey in compliance with 50 C.F.R. Parts 13, 17, 21, 22.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change the existing administrative regulation: The state will now solely oversee the propagation of indi-
viduals wishing to propagate raptors or practice falconry.
(b) The necessity of the amendment to this administrative regulation: The U.S. Fish and Wildlife Service is requiring all states to assume the responsibility for oversight of raptor propagation and falconry.
(c) How does the amendment conform to the authorizing statute: See “C” above.
(d) How the amendment will assist in the effective administration of the statutes: See “D” above.
(3) List the type and number of individuals, businesses, organizations, or state and local governments that will be affected: This regulation will affect falconers and captive wildlife permittees who hold raptors in Kentucky as well as nonresidents wishing to obtain a raptor within the state for falconry. There are approximately 57 falconry permittees and about 10 captive wildlife permittees in Kentucky. The number of nonresidents wishing to obtain a raptor varies from year to year but generally stays under 20 per year.
(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new of by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Individuals seeking renewal will submit a completed application, remit the appropriate fee, and provide a completed, signed copy of the raptor facility and equipment inspection form. Those individuals seeking to obtain a falconry permit for the first time will be required to take an exam and receive a passing mark (minimum score 80 per cent), along with submitting their application, raptor facility and equipment inspection form, fee and supporting materials. Nonresidents wishing to obtain a raptor will need a valid Kentucky nonresident hunting license, a valid falconry permit or equivalent from their home state, and an approved nonresident raptor take form from the Department. Note, these criteria are the same as the existing regulation, however the state will administer the exam rather than the USFWS.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): A Kentucky falconry permit costs $75, but this amendment will not require or create any new costs.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Individuals will have less waiting time since there will only be a State permit issued and historically the federal permit could take extended periods of time to obtain. Also, individuals will now only have to submit one fee. This will streamline the process for the user.
(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: Department costs to administer this administrative regulation will be offset by the permit fee.
(b) On a continuing basis: There will be no additional cost to the agency to implement this administrative regulation on a continuing basis.
(6) What is the source of funding to be used for implementation and enforcement of this administrative regulation? The source of funding is the State Game and Fish Fund.
(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. No increase in fees or funding will be necessary to implement this administrative regulation.
(8) State whether or not this administrative regulation establishes any fees directly or indirectly increases any fees: This administrative regulation does not establish any fees directly or indirectly.
(9) TIERING: Is tiering applied? Tiering was not used because this administrative regulation applies equally to all falconers and raptor propagators.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department of Fish and Wildlife and Wildlife Resources’ Divisions of Wildlife and Law Enforcement will be impacted by this administrative regulation.
(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 150.025(1) authorizes the department to promulgate administrative regulations establishing open seasons for the taking of wildlife, bag limits, and methods of taking wildlife, and to make these requirements apply to a limited area. KRS 150.280(1) requires the department to promulgate administrative regulations establishing procedures for propagating and holding of protected wildlife. 50 C.F.R. Parts 13, 17, 21, and 22 establish requirements for permitting, taking, possessing, and selling of raptors and endangered and threatened species.
(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The permit fee will generate approximately $5,000 for the department for the first year.
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The permit fee will generate approximately $5,000 for the department for subsequent years.
(c) How much will it cost to administer this program for the first year? The cost to administer the program will be offset by permit revenue during the first year.
(d) How much will it cost to administer this program for subsequent years? The cost to administer the program will be offset by permit revenue in subsequent years.
Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-):
Expenditures (+/-):
Other Explanation:

FEDERAL MANDATE ANALYSIS COMPARISON

2. State compliance standards. The Department of Fish and Wildlife Resources is now required to set falconry requirements and seasons which are within the frameworks established by the U.S. Fish and Wildlife Service and published in 50 C.F.R. Parts 21 and 22.
3. Minimum or uniform standards contained in the federal mandate. 50 C.F.R. Parts 21 and 22 contain minimum federal standards governing falconry, including falconry possession limits, permit requirements, facilities and care standards, and reporting requirements.
4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? Yes.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The federal mandate defines the species and possession limits falconers are allowed for falconry purposes. States are permitted to be more restrictive, but not more liberal in their respective regulations. Kentucky will be more restrictive in the possession limits of certain raptor species that are of conservation concern in the state.

PUBLIC PROTECTION CABINET
Department of Housing, Buildings and Construction
Division of Building Codes Enforcement
(Amendment)

815 KAR 35:060. Licensing of electrical contractors, electricians, and master electricians pursuant to KRS 227A.060.
RELATES TO: KRS Chapter 13B, 164.772(3), 227A.010, 227A.060, 227A.100, 339.230, 29 C.F.R. 570
STATUTORY AUTHORITY: KRS 227A.040(1), (8), 227A.060, 227A.100(9)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 227A.040 and 227A.060 authorize the Department of Housing, Buildings and Construction to promulgate administrative regulations to establish a process for the licensing of electrical contractors, electricians, and master electricians. KRS 227A.100(9) authorizes the department to promulgate administrative regulations governing an inactive license. This administrative regulation establishes the eligibility requirements and application procedures for the licensing of electrical contractors, electricians, and master electricians.

Section 1. Application Procedure. An applicant for licensure pursuant to KRS 227A.060 shall:
(1) Complete an application as required by Section 2 of this administrative regulation;
(2) Pay the application fee required by Section 3 of this administrative regulation;
(3) Provide verifiable evidence of experience and training as specified in Section 4 of this administrative regulation; and
(4) Provide evidence of passage of the examination required by Section 5 of this administrative regulation.

Section 2. Application Requirements. (1) The applicant shall complete an application form, either Electrical Contractor’s License Application, Form BCE-EL-2, or Electrical License Application Form, BCE-EL-3, which shall include the following information:
(a) The applicant’s name;
(b) The applicant’s home address;
(c) The applicant’s business address;
(d) The applicant’s home and business telephone numbers;
(e) The applicant’s date of birth;
(f) The applicant’s Social Security number or employer identification number;
(g) The applicant’s email address;
(h) The licenses applied for;
(i) For master electrician or electrician, a narrative listing of the applicant’s experience in the electrical industry, including:
1. Business name and address;
2. Job title;
3. Supervisor’s name;
(j) For master electrician or electrician, a listing of all approved training or apprenticeship programs the applicant has completed;
(k) A statement confirming that the applicant is not in default on

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Section 5. Examinations. (1) An applicant for an electrical contractor's license, master electrician's license, or electrician's license shall pass an examination administered by an approved examination provider. A passing score shall be valid for a period of three (3) years.

(2) For an electrical contractor's license, an applicant that is a business entity shall designate a person to take the examination on behalf of the applicant. The designee shall be:
   (a) An owner of the applicant;
   (b) An officer of the applicant;
   (c) A director of the applicant; or
   (d) A full-time employee of the applicant.

(3) If a person designated by an entity as provided in subsection (2) of this section leaves the employment or no longer maintains an interest in that entity, the entity shall designate another person who either:
   1. Has passed the examination; or
   2. Successfully passes the examination within thirty (30) days.

(b) Failure to have a designee that has passed the examination shall render the licensee no longer qualified to be licensed.

(4) Upon application by a testing agency, a national code group, or by an applicant for certification, the department may recognize another examination as equivalent to an examination administered by an approved examination provider. The person or group submitting the examination shall demonstrate that the examination covers the same material and requires the same level of knowledge as the approved examinations.

Section 6. Appeal Procedure. (1) An applicant denied a license may appeal the decision to the Commissioner of the Department of Housing, Buildings, and Construction. The applicant shall submit written notice of the appeal to the Department of Housing, Buildings, and Construction. The applicant shall submit written notice of the appeal to the Department of Housing, Buildings, and Construction.

(2) The appeal shall be conducted pursuant to KRS Chapter 13B by a hearing officer appointed by the Commissioner of the Department of Housing, Buildings, and Construction.

Section 7. Proof of Insurance. (1) An applicant for an electrical contractor's license shall provide proof of compliance with liability insurance requirements by providing an insurance certificate showing general liability insurance coverage of at least $500,000 issued by an insurer authorized to do business in Kentucky and naming the Department of Housing, Buildings, and Construction as the certificate holder.

(2) The applicant shall provide proof of workers' compensation insurance by providing:
   (a) An insurance certificate from an approved insurance provider with the Kentucky Department of Insurance; or
   (b) A notarized statement that the applicant is not required to obtain workers' compensation coverage and the reason why the coverage is not required.

(3) Electrical contractors shall require their liability and workers' compensation insurers to provide notice to the Department of Housing, Buildings, and Construction if:
   (a) A policy is canceled, terminated, or not renewed; or
   (b) The policy limits are lowered.

(4) Electrical contractors shall advise the Department of Housing, Buildings, and Construction of a:
   (a) Change in their insurance coverage, including cancellation or termination of any policy;
   (b) Change in the insurer providing the coverage; or
   (c) Changed circumstances that require the contractor to obtain coverage.

Section 8. Renewal Requirements. (1) A license shall be valid for one (1) year and shall be renewed on or before the last day of the licensee's birth month. For electrical contractor licenses issued to corporations, partnerships, or business entities without a birth month, the renewal month shall be the month the license was issued.

(2) The Department of Housing, Buildings, and Construction shall issue an initial license to an applicant for a period of up to twenty-three (23) months and shall charge a pro rata initial license fee for an active license.

(3) The fee to return a license to an active status from an inactive status shall be the remaining one-half (1/2) renewal fee for that year.

(4) The reinstatement fee for any lapsed license pursuant to KRS 227A.100(4) shall be equal to the license renewal fee and shall be paid in addition to the license renewal fee.

(5) The late renewal fee shall be fifty (50) dollars. If all documents required to be submitted for renewal are postmarked on or before the last day of the renewal month, the filing shall be considered timely and a late fee shall not be assessed.

(6) Renewal fees for inactive licenses shall be one-half (1/2) the fee for an active license.

Section 4. Verification of Experience. (1) An applicant shall submit verification of experience for licensure as a master electrician or electrician.

(2) Verification shall be submitted in the form of:
   (a) Tax returns or other official tax documents that indicate the applicant's occupation or the nature of the applicant's business activities, including Federal Schedule C, Form W-2, Form 1099, or local occupational tax returns;
   (b) A copy of a business license issued by a county or municipal government that did not issue electrical contractors, master electrician's, or electrician's licenses prior to June 24, 2003, if the business license indicates the applicant operated as an electrical contractor or worker;
   (c) A sworn affidavit, on the affiant's letterhead, certifying that the affiant has personal knowledge that the applicant has worked as a master electrician or an electrician for at least one (1) of the following:
      1. An electrical workers union;
      2. A certified electrical inspector; or
      3. An employer that employed the applicant as an electrician or a master electrician; or
   (d) A f

(3) Records of a branch of the United States Armed Forces that indicate the applicant performed a function that primarily involved electrical work.

(4) Experience gained while in the military shall be deemed to have been earned in Kentucky.

(5) One (1) year of electrical experience shall consist minimally of 1,600 hours of electrical work in a contiguous twelve (12) month period.
fee to reflect the actual term of the initial license. An initial license shall not be issued for less than a twelve (12) month period.

(3) A licensee shall apply for license renewal on Electrical License Renewal Application, Form BCE-EL-5.

Section 9. Inactive License Status. (1)(a) A licensee may request that a license be placed in inactive status.

(b) A licensee shall not perform electrical work requiring a license if the license is inactive.

(2) An electrical contractor licensee in inactive status shall not be required to maintain liability insurance or provide proof to the Department of Housing, Buildings, and Construction of compliance with workers’ compensation laws.

(3) A certified electrical inspector may be licensed as an electrical contractor, master electrician, or electrician, but shall maintain that license as inactive while having an active electrical inspector certification.

(4) Performing electrical work that requires a license while holding an inactive license shall be grounds for revocation or suspension of all electrical licenses and certifications held by the licensee.

Section 10. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Form BCE-EL-2, "Electrical Contractor’s License Application", March, 2007 edition;
(b) Form BCE-EL-3, "Electrical License Application", May 2011 edition;
(c) Form BCE-EL-4, "Reciprocity Electrical License Application," August 2009 edition; and

This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Housing, Buildings, and Construction, Electrical Licensing, 101 Sea Hero Road, Suite 100, Frankfort, Kentucky 40601-5405, Monday through Friday, 8 a.m. to 4:30 p.m.

AMBROSE WILSON IV, Commissioner
ROBERT D. VANCE, Secretary
APPROVED BY AGENCY: January 15, 2013
FILED WITH LRC: January 15, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 26, 2013, at 9:00 a.m., EDT, in the Department of Housing, Buildings, and Construction, 101 Sea Hero Road, Suite 100, Frankfort, Kentucky. Individuals interested in being heard at this hearing shall notify this agency in writing by February 19, 2013 (five working days prior to the hearing) of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the above date and contact person.

CONTACT PERSON: Dawn M. Bellis, General Counsel, Department of Housing, Buildings, and Construction, 101 Sea Hero Road, Suite 100, Frankfort, Kentucky 40601-5405, phone (502) 573-0365, fax (502) 573-1057.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Dawn M. Bellis

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the eligibility requirements and application procedures for the licensing of electrical contractors, electricians and master electricians under the provisions of 227A.060.

(b) The necessity of this administrative regulation: This admin-
1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by the administrative regulation? The Kentucky Department of Housing, Buildings and Construction, Electrical Licensing Section, will be impacted by this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. The statutory authority for this administrative regulation is found in KRS 227A.040(1), KRS 227A.040(8), KRS 227A.060 and KRS 227A.100(9).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. This administrative regulatory amendment will clarify existing language regarding the minimum number of work hours within a 12 month period which would meet work experience to qualify for licensure.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulatory amendment will not generate revenue.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate revenue.

(c) How much will it cost to administer this program for the first year? There will be no additional cost as this administrative regulatory amendment simply clarifies language already in the regulation.

(d) How much will it cost to administer this program for subsequent years? There will also be no additional cost to administer this program for subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES
Office of Health Policy

( Amendment )

900 KAR 7:030. Data reporting by health care providers.

RELATES TO: KRS Chapter 13B, 216.2920-216.2929
STATUTORY AUTHORITY: KRS 216.2923(3), 216.2925
NECESSITY, FUNCTION, AND CONFORMITY: KRS 216.2925 requires that the Cabinet for Health and Family Services promulgate administrative regulations requiring specified health care providers to provide the cabinet with data on cost, quality, and outcomes of health care services provided in the Commonwealth. KRS 216.2923(3) authorizes the cabinet to promulgate administrative regulations to impose fines for failure to report required data. This administrative regulation establishes the required data elements, forms, and timetables for submission of data to the cabinet and fines for noncompliance.

Section 1. Definitions. (1) “Agent” means any entity with which the cabinet may contract to carry out its statutory mandates, and which it may designate to act on behalf of the cabinet to collect, edit, or analyze data from providers.

(2) “Ambulatory facility” is defined by KRS 216.2920(1).

(3) “Cabinet” is defined by KRS 216.2920(2).

(4) “Coding and transmission specifications,” “Kentucky Inpatient and Outpatient Data Coordinator’s Manual for Hospitals,” or “Kentucky Data Coordinator’s Manual for Ambulatory Facilities” means the document containing the technical directives the cabinet issues concerning technical matters subject to frequent change, including codes and data for uniform provider entry into particular character positions and fields of the standard billing form and uniform provider formatting of fields and character positions for purposes of electronic data transmissions.

(5) “Hospital” is defined by KRS 216.2920(6).

(6) “Hospitalization” means the inpatient medical episode identified by a patient’s admission date, length of stay, and discharge date that is identified by a provider-assigned patient control number unique to that inpatient episode, except for:

(a) Inpatient services a hospital may provide in swing, nursing facility, skilled, intermediate or personal care beds; or

(b) Hospice care.

(7) “National Provider Identifier” or “NPI” means the unique identifier assigned by the Centers for Medicare and Medicaid Services to an individual or entity that provides health care services and supplies.

(8) “Outpatient services” means services performed on an outpatient basis in a hospital in accordance with Section 3(2) of this administrative regulation or services performed on an outpatient basis by an ambulatory facility in accordance with Section 4 of this administrative regulation.

(9) “Provider” means a hospital, ambulatory facility, clinic, or other entity of any nature providing hospitalizations, mammograms, or outpatient services as defined in the Kentucky Inpatient and Outpatient Data Coordinator’s Manual for Hospitals or the Kentucky Data Coordinator’s Manual for Ambulatory Facilities.

(10) “Record” means the documentation of a hospitalization or outpatient service in the format prescribed by the Kentucky Inpatient and Outpatient Data Coordinator’s Manual for Hospitals or the Kentucky Data Coordinator’s Manual for Ambulatory Facilities approved by the Statewide Data Advisory Committee on a computer readable electronic medium.

(11) “Standard Billing Form” means the uniform health insurance claim form pursuant to KRS 304.14-135, the Professional B37 (ASC X12N 837) format, the Institutional 837 (ASC X12N 837) format for its successor as adopted by the Centers for Medicare and Medicaid Services, or the HCFA 1500 for use by hospitals and other providers in billing for hospitalizations and outpatient services.

Section 2. Medicare Provider-Based Entity. A licensed outpatient facility that is a Medicare provider-based entity of a hospital and reports under the hospital’s provider number shall be separately identifiable through a facility-specific NPI.

Section 3. Data Collection for Hospitals. (1) Inpatient Hospitalization records. Hospitals shall document every hospitalization they provide on a Standard Billing Form and shall, from every record, copy and provide to the cabinet the data specified in Section 13 of this administrative regulation.

(2) Outpatient services records.

(a) Hospitals shall document on a Standard Billing Form the outpatient services they provide and shall from every record, copy and provide to the cabinet the data specified in Section 13 of this administrative regulation.

(b) Hospitals shall submit records that contain the required outpatient services procedure codes specified in the Kentucky Inpatient and Outpatient Data Coordinator’s Manual for Hospitals.

(3) Data collection on patients. Hospitals shall submit required data on every patient as provided in Section 13 of this administrative regulation, regardless of the patient’s billing or payment status.

Section 4. Data Collection for Ambulatory Facilities. (1) Outpatient Services Records.

(a) Ambulatory facilities shall document on a Standard Billing Form the outpatient services they provide and shall, from every record, copy and provide to the cabinet the data specified in Section 14 of this administrative regulation.

(b) Ambulatory facilities shall submit records that contain the required outpatient services procedure codes specified in the Kentucky Data Coordinator’s Manual for Ambulatory Facilities.

(2) Data collection on patients. Ambulatory facilities shall submit required data on every patient as provided in Section 14 of this administrative regulation, regardless of the patient’s billing or payment status.

Section 5. Data Finalization and Submission by Providers. (1)
Submission of final data.

(a) Data shall be final for purposes of submission to the cabinet as soon as a record is sufficiently final that the provider could submit it to a payor for billing purposes, regardless of whether the record has actually been submitted to a payor.

(b) Finalized data shall not be withheld from submission to the cabinet on grounds that it remains subject to adjudication by a payor.

(c) Data on hospitalizations shall not be submitted to the cabinet before a patient is discharged and before the record is sufficiently final that it could be used for billing.

(2) Data transmission responsibility.

(a) If a patient is served by a mobile health service, specialized medical technology service, or another situation where one (1) provider provides services under contract or other arrangement with another provider, responsibility for providing the specified data to the cabinet shall reside with the provider that bills for the service or would do so if a service is unbilled.

(b) Charges for physician services provided within a hospital shall be reported to the cabinet.

1. Responsibility for reporting the physician charge data shall rest with the hospital if the physician is an employee of the hospital.

2. A physician charge contained within a record generated by a hospital shall be clearly identified in a separate field within the record so that the cabinet may ensure comparability when aggregating data with other hospital records that do not contain physician charges.

(3) Transmission of records.

(a) Records submitted to the cabinet by hospitals shall be uniformly completed and formatted according to coding and transmission specifications set forth by the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals.

(b) Records submitted to the cabinet by ambulatory facilities shall be uniformly completed and formatted according to coding and transmission specifications set forth by the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

(c) All providers shall submit records on computer-readable electronic media.

(d) Providers shall provide back-up security against accidental erasure or loss of the data until all incomplete or inaccurate records identified by the cabinet have been corrected and resubmitted.

(4) Verification and audit trail for electronic data submissions.

(a) Each provider shall maintain a date log of data submissions and the number of records contained in each submission, and shall make the log available for inspection upon request by the cabinet.

(b) The cabinet shall, within twenty-four (24) hours of submission, verify by electronic message to each provider the receipt of the provider’s data transmissions and the number of records in each transmission.

(c) A provider shall immediately notify the cabinet of a discrepancy between the provider’s data log and a verification notice.

Section 6. Data Submission Timetable for Providers. (1) Quarterly submissions. Providers shall submit data at least once for each calendar quarter. A quarterly submission shall:

(a) Contain data, which during that quarter became final as specified in Section 5(1) of this administrative regulation; and

(b) Be submitted to the cabinet not later than forty-five (45) days after the last day of the quarter.

1. Calendar quarters shall be January 1 through March 31, April 1 through June 30, July 1 through September 30, and October 1 through December 31.

(2) Submissions more frequent than quarterly. Providers may submit data after records become final as specified in Section 5(1) of this administrative regulation and at a reasonable frequency convenient to a provider for accumulating and submitting batch data.

Section 7. Data Corrections for Hospitals. (1) Editing. Data received by the cabinet shall, upon receipt, be edited to ensure completeness and validity of the data. Computer editing routines shall identify for correction every record in which the submitted contents of required fields are not consistent with the cabinet’s coding and transmission specifications contained in the Kentucky Inpatient and Outpatient Data Coordinator’s Manual for Hospitals.

(2) Time permitted for corrections. The cabinet shall allow providers thirty (30) days in which to submit corrected copies of initially submitted data the cabinet identifies as incomplete or invalid as a result of edits.

(a) The thirty (30) days shall begin on the date of the cabinet’s notice informing the provider that corrections are required.

(b) Providers shall submit corrected data by electronic transmission or postmarked mailing within thirty (30) days.

(c) Corrected data submitted to the cabinet shall be uniformly completed and formatted according to the cabinet’s coding and transmission specifications contained in the Kentucky Inpatient and Outpatient Data Coordinator’s Manual for Hospitals.

(3) Percentage error rate.

(a) When editing data upon its initial submission, the cabinet shall identify and return to the provider for correction every record in which one (1) or more of the required data elements fails to pass the edit.

(b) When editing data that a provider has submitted, the cabinet shall check for an error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.

(c) The cabinet may return for further correction any submission of allegedly corrected data in which the provider fails to achieve a corrected error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.

(d) For the first data submission, the cabinet shall not count as errors any data for patients admitted prior to thirty (30) days of the effective date of this administrative regulation.

Section 8. Data Corrections for Ambulatory Facilities. (1) Editing. Data received by the cabinet shall, upon receipt, be edited to ensure completeness and validity of the data. Computer editing routines shall identify for correction every record in which the submitted contents of required fields are not consistent with the cabinet’s coding and transmission specifications contained in the Kentucky Data Coordinator’s Manual for Ambulatory Facilities.

(2) Time permitted for corrections. The cabinet shall allow providers thirty (30) days in which to submit corrected copies of initially submitted data the cabinet identifies as incomplete or invalid as a result of edits.

(a) The thirty (30) days shall begin on the date of the cabinet’s notice informing the provider that corrections are required.

(b) Providers shall submit corrected data by electronic transmission or postmarked mailing within the thirty (30) days.

(c) Corrected data submitted to the cabinet shall be uniformly completed and formatted according to the cabinet’s coding and transmission specifications contained in the Kentucky Data Coordinator’s Manual for Ambulatory Facilities.

(d) The cabinet shall grant a provider an extension of time to submit corrections, if the provider has formally informed the cabinet of significant problems in performing the corrections and has formally requested, in writing, an extension of time beyond the thirty (30) day limit.

(3) Percentage error rate.

(a) When editing data upon its initial submission, the cabinet shall identify and return to the provider for correction every record in which one (1) or more of the required data elements fails to pass the edit.

(b) When editing data that a provider has submitted, the cabinet shall verify an error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.

(c) The cabinet may return for further correction any submission of allegedly corrected data in which the provider fails to achieve a corrected error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is more.
Section 9. Fines for Noncompliance for Providers. (1) A provider failing to meet quarterly submission guidelines as established in Sections 6, 7, and 8 of this administrative regulation shall be assessed a fine of $500 per violation.

(2) The cabinet shall notify a noncompliant provider by certified mail, return receipt requested, of the documentation of the reporting deficiency and the assessment of the fine.

(3) A provider shall have thirty (30) days from the date of receipt of the notification letter to pay the fine which shall be made payable to the Kentucky State Treasurer and sent by certified mail to the Kentucky Cabinet for Health and Family Services, Office of Health Policy, 275 East Main Street 4 W-E, Frankfort, Kentucky 40621.

(4) Fines during a calendar year shall not exceed $1,500 per provider.

Section 10. Extension or Waiver of Data Submission Timeframes. (1) Providers experiencing extenuating circumstances or hardships may request from the cabinet, in writing, a data submission extension or waiver.

(a) Providers shall request an extension or waiver from the Office of Health Policy on or before the last day of the data reporting period to receive an extension or waiver for that period.

(b) Extensions and waivers shall not exceed a continuous period of greater than six (6) months.

(2) The cabinet shall consider the following criteria in determining whether to grant an extension or waiver:

(a) Whether the request was made due to an event beyond the provider's control, such as a natural disaster, catastrophic event, or theft of necessary equipment or information;

(b) The severity of the event prompting the request; and

(c) Whether the provider continues to gather and submit the information necessary for billing.

(3) A provider shall not apply for more than three (3) extensions or waivers during a calendar year.

Section 11. Appeals for Providers. (1) A provider notified of its noncompliance and assessed a fine pursuant to Section 9(1) of this administrative regulation shall have the right to appeal within thirty (30) days of the date of the notification letter.

(a) If the provider believes the action by the cabinet is unfair, without reason, or unwarranted, and the provider wishes to appeal, it shall appear in writing to the Secretary of the Cabinet for Health and Family Services, 5th Floor, 275 East Main Street, Frankfort, Kentucky 40621.

(b) Appeals shall be filed in accordance with KRS Chapter 13B.

(2) Upon receipt of the appeal, the secretary or designee shall issue a notice of hearing no later than twenty (20) days before the date of the hearing. The notice of the hearing shall comply with KRS 13B.050. The secretary shall appoint a hearing officer to conduct the hearing in accordance with KRS Chapter 13B.

(3) The hearing officer shall issue a recommendation in accordance with KRS 13B.110. Upon receipt of the recommended order, following consideration of any exceptions filed pursuant to KRS 13B.110(4), the secretary shall enter a final decision pursuant to KRS 13B.120.

Section 12. Working Contacts for Providers. (1) By January 1 of each calendar year, a provider shall report by letter to the cabinet the names and telephone numbers of a designated contact person and one (1) back-up person to facilitate technical follow-up in data reporting and submission.

(a) A provider's designated contact and back-up shall not be the chief executive officer unless no other person employed by the provider has the requisite technical expertise.

(b) The designated contact shall be the person responsible for review of the provider's data for accuracy prior to the publication by the cabinet.

(2) If the chief executive officer, designated contact person, or back-up person changes during the year, the name of the replacing person shall be reported immediately to the cabinet.

Section 13. Required Data Elements for Hospitals. (1) Hospital...
Section 14. Required Data Elements for Ambulatory Facilities. (1) Ambulatory facilities shall ensure that each record submitted to the cabinet contains at least the data elements identified in this section and as provided on the Standard Billing Form.

(2) Asterisks identify elements that shall not be blank and shall contain data or a code as specified in the cabinet’s coding and transmission specifications contained in the Kentucky Data Coordinator’s Manual for Ambulatory Facilities.

(3) Additional data elements, as specified in the Kentucky Data Coordinator’s Manual for Ambulatory Facilities, shall be required by the cabinet to facilitate proper collection and identification of data.

Required DATA ELEMENT LABEL
Yes *Patient Birth date
Yes *Patient Sex
Yes *Zip Code
Yes *1st Individual Payer ID#
Yes *Admission/Start of Care Date
Yes *Type of Bill
Yes *Principal Diagnosis Code
Yes *Secondary and Other Diagnosis Codes if present
Yes *Principal Procedure Code & Date
Yes *Secondary and Other Procedure Codes & Date if present
Yes *1st Units of Service
Yes *1st Charge
No Secondary and Other Units of Service and Charge
Yes *Total Charges for the Case
Yes *Attending Clinician NPI
Yes *Provider Assigned Patient ID#
Yes *1st Insurer Group #
Yes 2nd Insurer Group #
Yes *Operating Clinician NPI
Yes *Billing Facility-specific NPI
Yes *Federal Tax Number or Employer Identification Number (EIN)
Yes *Statement Covers Period
Yes *Primary Payor Name
No Secondary Payor Name
Yes *Race
Yes *Ethnicity
Yes *HCPCS/Rates/Hipps Rate Codes

Section 15. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) “Kentucky Inpatient and Outpatient Data Coordinator’s Manual for Hospitals”, revised January 1, 2013[April 30, 2012]; and

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Cabinet for Health and Family Services, 275 East Main Street 4WE, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

This is to certify that the Executive Director of the Office of Health Policy has reviewed and recommended this administrative regulation prior to its adoption, as required by KRS 156.070(4).

ERIC FRIEDLANDER, Acting Executive Director AUDREY TAYSE HAYNES, Secretary APPROVED BY AGENCY: December 21, 2012 FILED WITH LRC: December 27, 2012 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2013, at 9:00 a.m. in the Public Health Auditorium located on the First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend is received at the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40621, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Diona Mullins or Chandra Venetozzi

1. Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation provides clarification and instruction to specified health care providers on the process necessary to submit copies of administrative claims data to the Cabinet.

(b) The necessity of the administrative regulation: This administrative regulation is necessary so that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data. The administrative regulation contains the updated data submission manuals for both hospitals and ambulatory facilities. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider for region 3 – Humana Medicaid Managed Care. Additionally changes were made to incorporate the 1) addition of the requirement to report newly created CPT/HCPCS codes, 2) new edits, and 3) a sample of new ad hoc report.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary so that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data to enable the Cabinet to publish the data and reports as required by KRS 216.2925.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed instructions to specified health care providers relating to the data elements, forms and timetables necessary to comply with statute.

2. If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This administrative regulation incorporates by reference updated data reporting manuals. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider for region 3 – Humana Medicaid Managed Care. Additionally changes were made to incorporate the 1) addition of the requirement to report newly created CPT/HCPCS codes, 2) new edits, and 3) a sample of new ad hoc report.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to provide new data submission manuals to facilities that submit data so that accuracy of the data is ensured.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment continues to conform to the content of the authorizing statutes by providing a standardized method of reporting by facilities.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the statutes as it provides detailed instructions on how to submit required data elements.

3. List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation will affect approximately 185 hospitals and ambulatory facilities that submit data to the Cabinet.

4. Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

- 1788 -
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Each entity will collect and submit data as required. Entities are already required to submit data, this regulation incorporates reference manuals that were revised due to the addition of one new payor code to identify a new Medicaid MCO provider for region 3 – Humana Medicaid Managed Care. Additionally changes were made to incorporate the 1) addition of the requirement to report newly created CPT/HCPCS codes, 2) new edits, and 3) a sample of new ad hoc report.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Each entity will collect and submit data as required. Entities are already required to submit data, this regulation incorporated by reference manuals that were revised to provide detailed submission requirements. Therefore, no additional cost will be incurred.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Data integrity is improved in all applicable payor codes are now included it the manuals and instructions have been provided related to the 1) addition of the requirement to report newly created CPT/HCPCS codes, 2) new edits, and 3) a sample of new ad hoc report.

5. Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: No additional costs will be incurred to implement this administrative regulation as the Office of Health Policy currently collects data and has the necessary data collection system in place.

(b) On a continuing basis: No additional costs will be incurred.

6. What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding to be used for the implementation and enforcement of this administrative regulation will be from Office of Health Policy’s existing budget.

7. Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary.

8. State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees and does not increase any fees either directly or indirectly.

9. TIERING: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This administrative regulation affects the Office of Health Policy within the Cabinet for Health and Family Services.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 216.2920-216.2929.

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect:

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation will not generate any revenue.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will not generate any revenue.

(c) How much will it cost to administer this program for the first year? No additional costs will be incurred to implement this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? No additional costs will be incurred to implement this administrative regulation on a continuing basis.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): Expenditures (+/-): Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES
Office of Inspector General
Division of Audits and Investigations
(Amendment)


RELATES TO: KRS 218A.010-218A.050, 21 C.F.R. 1308.11
STATUTORY AUTHORITY: KRS 194.050, 218A.020, 218A.040, 218A.250

NECESSITY, FUNCTION, AND CONFORMITY: KRS 218A.020 authorizes the Cabinet for Health and Family Services to add substances to or delete or reschedule substances enumerated in KRS Chapter 218A. After considering the criteria set forth in KRS 218A.020 and 218A.040 and applicable federal regulations, the Cabinet for Health and Family Services designates the substances set forth in this administrative regulation as Schedule I controlled substances.

This administrative regulation differs from the federal regulation because it designates substances that are substantially similar to synthetic cannabinoids as Schedule I controlled substances. The Cabinet for Health and Family Services recognizes that synthetic cannabinoids have significant abuse potential and inclusion on Kentucky’s Schedule I list will help reduce the risk to public health.

Section 1. Opiates. The Cabinet for Health and Family Services hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any of the following opiates, including their isomers, optical isomers, esters, ethers, salts, salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, ethers, esters, and salts is possible within the specific chemical designation:

(1) Alphacetylmethadol (except Levo-alphacetylmethadol LAAM):

(2) Acetyl-alpha-methylfentanyl, N-1-(1-methyl-2-phenethyl)-4-piperidinyl-N-phenylacetamide;

(3) Acetyl-alpha-methylfentanyl, N-1-(alpha-beta-benzyl-beta-phenylpropanamide; 1-(1-methyl-2-phenylethyl)-4-(N-propanilido) piperidine);

(4) Acetyl-thiofentanyl, N-1-methyl-2-(2-thienyl) ethyl-4-piperidinyl-N-phenylpropanamide;

(5) Benzylfentanyl, N-1-benzyl-4-piperidinyl-N-phenylpropanamide;

(6) Beta-hydroxyfentanyl, N-1-(2-hydroxy-2-phenethyl)-4-piperidinyl-N-phenylpropanamide;

(7) Beta-hydroxy-3-methylfentanyl, N-1-(2-hydroxy-2-phenethyl)-3-methyl-4-piperidinyl-N-phenylpropanamide;

(8) Difenoxin;

(9) 3-Methylfentanyl, N-3-methyl-1-(2-phenylethyl) 4-piperidinyl-N-phenylpropanamide;

(10) 3-methylthiofentanyl, N-3-methyl-1-(2-thienyl) ethyl-4-piperidinyl-N-phenylpropanamide;

(11) 1-methyl-4-phenyl-4-propionoxyxopiperidene (MPPP);

(12) Para-fluorofentanyl, N-(4-fluorophenyl)-N-1-(2-phenethyl) 4-piperidinylpropanamide;

(13) 1-(2-phenethyl)-4-phenyl-4-acetoxyxopiperidene (PEPAP);

(14) Thethylfentanyl, N-1-(2-thienyl) methyl-4-piperidinyl-N-phenylpropanamide;

(15) Thiofentanyl, N-phenyl-N-1-(2-thienyl)ethyl-4-piperidinylpropanamide; and

(16) Tilidine.

Section 2. Opium Derivatives. The Cabinet for Health and...
Family Services/Human Resources hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any of the following opium derivatives, their salts, optical isomers, isomers and salts of isomers, unless specifically excepted; whenever the existence of these salts, isomers, optical isomers, and salts of isomers is possible within the specific chemical designation:
(1) Drotebanol; and
(2) Etophrine (except hydrochloride salt).

Section 3. Hallucinogenic Substances. The Cabinet for Health and Family Services/Human Resources hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any material, compound, mixture, or preparation which contains any quantity of the following hallucinogenic substances, their salts, isomers and salts of isomers, unless specifically excepted; whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this paragraph only, the term “isomer” includes the optical position and geometric isomers):
(1) alpha-ethyltryptamine (alpha-ethyl-1H-indole-3-ethanamine, 3-(2-aminoindoly)indole);
(2) 4-bromo-2, 5-dimethoxyamphetamine (4-bromo-2,5-DMA, 4-bromo-2,5-dimethoxy-alpha-methylphenylethylamine);
(3) 2,5-dimethoxyamphetamine (2,5- DMA); (4) 2,5-dimethoxy-4-ethylamphetamine (DOET);
(5) Ethylamine analog of phencyclidine (N-ethyl-1-penylcyclohexylamine, cyclohexamine, (1-phenylcyclohexyl) ethylamine, N-(1-phenylcyclohexyl) ethylamine, PCE);
(6) 3,4-methylenedioxyamphetamine (MDMA);
(7) 4-methoxyamphetamine (PMA, 4-methoxy- alphamethylphenylethylamine, paramethoxyamphetamine);
(8) 3,4-methylenedioxy-N-ethylamphetamine (N-ethyl-alpha-methyl-3,4-methylenedioxyphenethylamine, N-ethyl MDMA, MDE, MDEA);
(9) N-hydroxy-3,4-methylenedioxyamphetamine (N-hydroxy-alpha-methyl-3,4-methylenedioxyphenethylamine, N-hydroxy MDMA);
(10) Parahexyl (Synhexyl, 3-Hexyl-1-hydroxy-7, 8, 9, 10-tetrahydro-6, 6, 9-trimethyl-6H-dibenz[b,d]pyran);
(11) Pyrrolidine analog of phencyclidine (1-(1-phenylcyclohexyl)pyrrolidine, PCPy, PHP);
(12) Thiophene analog of phencyclidine (1-(1-(2-thienyl)cyclohexyl)piperidine, TCP, TPCP); and
(13) 1,1-(2-thienyl)cyclohexylpyrrolidine (TCPy).

Section 4. Depressants. The Cabinet for Health and Family Services/Human Resources hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:
(1) Mectoqualone; and
(2) Methaqualone.

Section 5. Stimulants. The Cabinet for Health and Family Services/Human Resources hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:
(1) Aminorex (aminophenex, 2-amino-5-phenyl-2-oxazoline, 4,5-dihydro-5-phenyl-2-oxazoline);
(2) Cathinone (2-amino-1-phenyl-1-propanone, alpha-amino-piophenone, 2-amino-piophenone, and norephedrine);
(3) (±) cis-4-methylaminorex ((±) cis-4,5-dihydro-4-methyl-5-phenyl-2-oxazolamine);
(4) N,N-dimethylamphetamine (N,N-alpha-trimethyl-benzeneetha-namine, N,N-alpha-trimethylphenethylamine), its salts, optical isomers and salts of optical isomers;
(5) N-ethylamphetamine;
(6) N-ethanolamine;
(7) Methcathinone (2-(methylamino)-propiophenone, alpha (methylamino)-propiophenone, alpha (methylamino)-propiophenone, 2-(methylamino)-1-phenylpropan-1-one, alpha-N-methylaminopropiophene none, monomethylpropion, ephedrine, N-methylcathinone, methylcathinone, AL-464, AL-422, AL-463 and UR1431) its salts, optical isomers and salts of optical isomers.

Section 6. Synthetic Cannabinoids. The Cabinet for Health and Family Services hereby designates as Schedule I controlled substances, in addition to those specified by KRS 218A.050, any substance, compound, mixture, or preparation which contains any quantity of any synthetic cannabinoid and is not an FDA approved drug, including the following:
(1) 1-(4-ethyl-1H-indole-3-yl)-1H-inden-2-one (3-(1H-indene-1,2,3-trimethylcyclopentyl)methane (UR-144));
(2) 1-(1-(5-fluoropentyl)-1H-indole-3-yl)(2,2,3,3-tetramethylecyclopentyl)methane (XLR-11);
(3) 2-(2,5-dimethoxyphenyl)-N-(2-methoxyphenyl)methylmethane (2,5H-NBOME);
(4) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxyphenyl)methylmethane (2-IA-NBOME);
(5) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxyphenyl)methylmethane (2.5B-NBOME) and
(6) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxyphenyl)methylmethane (2.5C-NBOME).

MARY REINLE BEGLEY, Inspector General
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 12, 2012
FILED WITH LRC: December 19, 2012 at 9 a.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2013, at 9:00 a.m. in Auditorium A, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments regarding this proposed administrative regulation until close of business February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-E, Frankfort, Kentucky 40621, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT
Contact Person: Mary Reinele Begley, Stephanie Brammer-Barnes
(1) Provide a brief summary of:
(a) What this administrative regulation does: The substances set forth in this administrative regulation are designated as Schedule I controlled substances.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with KRS 218A.020.
(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 218A.020 mandates that the Cabinet for Health and Family Services add, delete, or rescind substances enumerated in the schedules set forth in KRS Chapter 218A. This administrative regulation designates Schedule I controlled substances.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This adminis-
trative regulation assists in the effective administration of the statutes by designating Schedule I controlled substances.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
   (a) How the amendment will change this existing administrative regulation: Under existing state law, certain formulations of synthetic cannabinoids are illegal. However, new variants of these drugs have appeared on the market as a legal alternative to marijuana. This amendment classifies substances that are substantially similar to synthetic cannabinoids as Schedule I controlled substances, thereby effectuating a complete ban on these types of products.
   (b) The necessity of the amendment to this administrative regulation: This amendment is necessary to address the growing threat of synthetic cannabinoids to the health, safety, and welfare of Kentucky’s citizens. Additionally, this action is consistent with the National Association of State Controlled Substances Authorities (NASCSA) October 2011 resolution encouraging the Drug Enforcement Administration and states to make synthetic cannabinoids Schedule I substances. A copy of NASCSA’s resolution may be downloaded at the following link: http://www.nascsoa.org/Resolutions/res11.09.pdf.
   (c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by designating substances that are substantially similar to synthetic cannabinoids as Schedule I substances.
   (d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the statutes by designating substances that are substantially similar to synthetic cannabinoids as Schedule I substances.

(3) List the type and number of individuals, businesses, organizations, or state or local governments affected by this administrative regulation: This regulation bans, from legal sale, chemical variations of synthetic cannabinoids that have been formulated as a legal alternative to marijuana. Since these products are sold at commercial retail shops, the ban imposed by this regulation would compel retailers to stop selling these substances and enable law enforcement to halt illegal sales.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
   (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Commercial retail shops that currently sell chemical variations of synthetic cannabinoids that have been formulated as a legal alternative to marijuana would be required to stop selling these products.
   (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No additional costs will be incurred by retailers in order to comply with this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3)? Compliance with this amendment will help address the growing threat of synthetic cannabinoids to the health, safety, and welfare of Kentucky’s citizens.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
   (a) Initially: This administrative body will not incur additional costs to implement the changes made by this amendment.
   (b) On a continuing basis: This administrative body will not incur additional costs to implement the changes made by this amendment.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding to be used for the implementation and enforcement of this administrative regulation will be agency funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding will be necessary to implement this amended administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: The amendment to this administrative regulation will not establish or increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applicable as compliance with this administrative regulation applies equally to all individuals or entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Local governments will expend funds to arrest, prosecute, and incarcerate convicted defendants for trafficking, possessing, and manufacturing synthetic cannabinoids. Additionally, as these substances are new types of illegal drugs, there may be some additional cost in training law enforcement officers to recognize these drugs and deal with individuals under the influence. However, this regulation, in combination with existing laws, will accomplish a total ban on these drugs before they get a foothold in Kentucky and thereby eradicate the problem of use and abuse.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 218A.020.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first year that this administrative regulation is in effect.
   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? There will be no additional revenue generated for state or local government for the first year.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? There will be no additional revenue generated for state or local government for the first year.

   (c) How much will it cost to administer this program for the first year? There may be additional incarcerations related to this administrative regulation. While the expense of housing inmates may vary widely by jail, each additional inmate will increase facility costs by an estimated average of $31.34 per day.

   (d) How much will it cost to administer this program for subsequent years? There may be additional incarcerations related to this administrative regulation. While the expense of housing inmates may vary widely by jail, each additional inmate will increase facility costs by an estimated average of $31.34 per day.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/\-):

Expenditures (+/\-):

Other Explanation:

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 21 C.F.R. Section 1308.11 establishes the federal listing of Schedule I controlled substances.

2. State compliance standards. KRS 218A.020 permits the Cabinet for Health and Family Services to adopt a regulation to control a substance if it finds the substance has a potential for abuse.

3. Minimum or uniform standards contained in the federal mandate. The federal schedules of controlled substances are established in the federal mandate.

   2. State compliance standards. KRS 218A.020 establishes the federal listing of Schedule I controlled substances.

   3. Minimum or uniform standards contained in the federal mandate. The federal schedules of controlled substances are established in the federal mandate.
CABINET FOR HEALTH AND FAMILY SERVICES  
Department for Medicaid Services  
Commissioner’s Office  
(AMENDMENT)

907 KAR 17:005. Definitions for 907 KAR Chapter 17 [Managed care organization requirements and policies].

RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R. 438


NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to complement a management that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the definitions for 907 KAR Chapter 17, which apply to the policies and procedures relating to the provision of Medicaid services through contracted managed care organizations pursuant to, and in accordance with, 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438.

Section 1. Definitions. (1) “1915(c) home and community based waiver program” means a Kentucky Medicaid program established pursuant to, and in accordance with, 42 U.S.C. 1396n(c).

(2) “Advanced practice registered nurse” is defined by KRS 314.011(7).

(3) “Adverse action” means:
  (a) The denial or limited authorization of a requested service, including the type or level of service;
  (b) The reduction, suspension, or termination of a previously authorized service;
  (c) The denial, in whole or in part, of payment for a service;
  (d) The failure to provide services in a timely manner;
  (e) The failure of a managed care organization to act within the timeframes provided in 42 C.F.R. 438.408;
  (f) The denial of payment.

(4) “Aged” means at least sixty-five (65) years of age.

(5) “Appeal” means a request for review of an adverse action or a decision by an MCO related to a covered service.

(6) “Authorized representative” means an individual or entity acting on behalf of, and with written consent from, an enrollee.

(7) “Behavioral health service” means a clinical, rehabilitative, or support service in an inpatient or outpatient setting to treat a mental illness, emotional disability, or substance abuse disorder.

(8) “Blind” is defined by 42 U.S.C. 1382c(a)(2).

(9) “Capitation payment” means the total per enrollee, per month payment amount the department pays an MCO.

(10) “Capitation rate” means the negotiated amount to be paid on a monthly basis by the department to an MCO:
  (a) Per enrollee; and
  (b) Based on the enrollee’s aid category, age, and gender.

(11) “Care coordination” means the integration of all processes in response to an enrollee’s needs and strengths to ensure the:
  (a) Achievement of desired outcomes; and
  (b) Effectiveness of services.

(12) “Case management” means a collaborative process that:
  (a) Assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an enrollee’s health and human service needs; and
  (b) Is characterized by advocacy, communication, and re-source management;
  (c) Promotes quality and cost-effective interventions and outcomes; and
  (d) Is in addition to and not in lieu of targeted case management.

1. Adults with a chronic mental illness pursuant to 907 KAR 1:515;
2. Children with a severe emotional disability pursuant to 907 KAR 1:525.


[15][14] “Child” means a person who:
  (a) Is under the age of eighteen (18) years;
  (b) Is a full-time student in a secondary school or the equivalent level of vocational or technical training; and
  (c) Is expected to complete the program before the age of nineteen (19) years;
3. Is not self-supporting;
4. Is not a participant in any of the United States Armed Forces; and
5. If previously emancipated by marriage, has returned to the home of his or her parents or to the home of another relative;
   (b) Has not attained the age of nineteen (19) years in accordance with 42 U.S.C. 1396a(i)(1)(D); or
   (c) Is under the age of nineteen (19) years if the person is a KCHIP recipient.

[15][14] “Chronic Illness and Disability Payment System” means a diagnostic classification system that Medicaid programs use to make health-based, capitated payments for TANF and Medicaid beneficiaries with a disability.

[16][14] “Commission for Children with Special Health Care Needs” or “CCSHCN” means the Title V agency which provides specialty medical services for children with specific diagnoses and health care needs that make them eligible to participate in programs sponsored by the CCSHCN, including the provision of medical care.

[17][16] “Community mental health center” means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

[18][17] “Complex or chronic condition” means a physical, behavioral, or developmental condition which:
  (a) May have no known cure;
  (b) Is progressive; or
  (c) Can be debilitating or fatal if left untreated or under-treated.

[19][16] “Consumer Assessment of Healthcare Providers and Systems” or “CAHPS” means a program that develops standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care.

[20][14] “Court-ordered commitment” means an involuntary commitment by an order of a court to a psychiatric facility for treatment pursuant to KRS Chapter 202A.

[21][16] “DAIL” means the Department for Aging and Independent Living.

[22][21] “DCBS” means the Department for Community Based Services.

[23][22] “Department” means the Department for Medicaid Services or its designee.


[27][26] “Early and periodic screening, diagnosis and treatment” or “EPSDT” is defined by 42 C.F.R. 440.40(b).


[29][28] “Encounter” means a health care visit of any type by a recipient to a provider of care, drugs, items, or services.

[30][29] “Enrollee” means a recipient who is enrolled with a Medicaid or KCHIP covered services.

[31][30] “External quality review organization” or “EQRO”:
  (a) Is defined by 42 C.F.R. 438.320; and

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“Family planning service” means a counseling service, medical service, or a pharmaceutical supply or device to prevent or delay pregnancy.

“Fee-for-service” means a reimbursement model in which a health insurer reimburses a provider for each service provided to a recipient.

“Foster care” is defined by KRS 620.020(5).

“Fraud” means any act that constitutes fraud under applicable federal law or KRS 205.8451 to KRS 205.8493.

“Grievance” is defined by 42 C.F.R. 438.400.

“Grievance system” means a system that includes a grievance process, an appeal process, and access to the Commonwealth of Kentucky’s fair hearing system.

“Health maintenance organization” is defined by KRS 304.38-030(5).

“Health risk assessment” or “HRA” means a health questionnaire used to provide individuals with an evaluation of their health risks and quality of life.

“Healthcare Effectiveness Data and Information Set” or “HEDIS” means a tool used to measure performance regarding important dimensions of health care or services.

“Homeless individual” means an individual who:
(a) Lacks a fixed, regular, or nighttime residence;
(b) Is at risk of becoming homeless in a rural or urban area because the residence is not safe, decent, sanitary, or secure;
(c) Has a primary nighttime residence at a:
 1. Publicly or privately operated shelter designed to provide temporary living accommodations; or
 2. Public or private place not designed as regular sleeping accommodations; or
(d) Lacks access to normal accommodations due to violence or the threat of violence from a cohabitant.

“Individual with a special health care need” or “ISHCN” means an individual who:
(a) Has, or is at a high risk of having, a chronic physical, developmental, behavioral, neurological, or emotional condition; and
(b) May require a broad range of primary, specialized, medical, behavioral health, or related services.

“Implementation” means the process of transitioning a current Medicaid or KCHIP recipient from fee-for-service into managed care.

“KCHIP” means the Kentucky Children’s Health Insurance Program administered in accordance with 42 U.S.C. 1397aa to ".

“Kentucky Health Information Exchange” or “KHIE” means the name given to the system that will support the statewide electronic exchange of health information among healthcare providers and organizations according to nationally-recognized standards.

“Managed care organization” or “MCO” means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

“Marketing” means any activity conducted by or on behalf of an MCO in which information regarding the services offered by the MCO is disseminated in order to educate enrollees or potential enrollees about the MCO’s services.

“Maternity care” means prenatal, delivery, and postpartum care and includes care related to complications from delivery.

“Medicaid works individual” means an individual who:
(a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be receiving SSI benefits;
(b) Is at least sixteen (16), but less than sixty-five (65), years of age;
(c) Is engaged in active employment verifiable with:
 1. Paycheck stubs;
 2. Tax returns;
 3. 1099 forms; or
 4. Proof of quarterly estimated tax;
(d) Meets the income standards established in 907 KAR 1:640;
(e) Meets the resource standards established in 907 KAR 1:645.

“Medical record” means a single, complete record that documents all of the treatment plans developed for, and medical services received by, an individual.

“Medically necessary” means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

“Medicare qualified individual group 1 (GI-1)” means an eligibility category, in which pursuant to 42 U.S.C. 1396a(a)(10)(E)(iv), an individual who would be a Qualified Medicaid beneficiary but for the fact that the individual’s income:
(a) Exceeds the income level established in accordance with 42 U.S.C. 1396d(p)(2); and
(b) Is at least 120 percent, but less than 135 percent, of the federal poverty level for a family of the size involved and who are not otherwise eligible for Medicaid under the state plan.

“National Practitioner Data Bank” means an electronic database that collects:
(a) Information on adverse licensure activities, certain actions restricting clinical privileges, and professional society membership actions taken against physicians, dentists, and other practitioners; and
(b) Data on payments made on behalf of physicians in connection with liability settlements and judgments.

“Nonqualified alien” means a resident of the United States of America who does not meet the qualified alien requirements established in 907 KAR 1:011, section 5(12).

“Nursing facility” means:
(a) A facility:
 1. To which the state survey agency has granted a nursing facility license;
 2. For which the state survey agency has recommended to the department certification as a Medicaid provider; and
3. To which the department has granted certification for Medicaid participation; or
(b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395t and 1396, if the swing bed is certified to the department as meeting requirements for the provision of swing bed services in accordance with 42 U.S.C. 1396b(c), (d), and (e) and 42 C.F.R. 447.280 and 447.66.

“Olmstead decision” means the court decision of Olmstead v. L.C. and E.W., U.S. Supreme Court, No. 98–536, June 26, 1999 in which the U.S. Supreme Court ruled, “For the reasons stated, we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.”

“Open enrollment” means an annual period during which an enrollee can choose a different MCO.

“Out-of-network provider” means a person or entity that has not entered into a participating provider agreement with an MCO or any of the MCO’s subcontractors.

“Physician” is defined by KRS 311.550(12).

“Post-stabilization services” means covered services related to an emergency medical condition that are provided to an enrollee:
(a) After an enrollee is stabilized in order to maintain the stabilized condition; or
(b) Under the circumstances described in 42 C.F.R. 438.114(e) to improve or resolve the enrollee’s condition.

“Primary care center” means an entity that meets the primary care center requirements established in 902 KAR 20:058.

“Primary care provider” or “PCP” means a licensed or certified health care practitioner who meets the description as established in 907 KAR 17:010, section 7(6)(c) [of this administrative regulation].

“Prior authorization” means the advance approval by an MCO of a service or item provided to an enrollee.

“Provider” means any person or entity under contract with an MCO or its contractual agent that provides covered servic-
es to enrollees.

66[(65)] "Provider network" means the group of physicians, hospitals, and other medical care professionals that a managed care organization has contracted with to deliver medical services to its enrollees.

67[(66)] "OAPI" means the Quality Assessment and Performance Improvement Program established in accordance with 907 KAR 17:025, Section 5 [Section 48 of this administrative regulation].

68[(67)] "Qualified alien" means an alien who, at the time of applying for or receiving Medicaid benefits, meets the requirements established in 907 KAR 1:011, Section 5(12).

69[(68)] "Qualified disabled and working individual" is defined by 42 U.S.C. 1396a(s).

70[(69)] "Qualified Medicare beneficiary" or "QMB" is defined by 42 U.S.C. 1396d(p)(1).

71[(70)] "Quality improvement" or "QI" means the process of assuring that covered services provided to enrollees are appropriate, timely, accessible, available, and medically necessary and the level of performance of key processes and outcomes of the health care delivery system is improved through the MCO’s policies and procedures.

72[(71)] "Recipient" is defined in KRS 205.8451(9).

73[(72)] "Region eight (8)" means the region containing Bell, Brevard, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe Counties.

74[(73)] "Region five (5)" means the region containing Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, and Woodford Counties.

75[(74)] "Region four (4)" means the region containing Adair, Allen, Barrren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Hanover, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, and Wayne Counties.

76[(75)] "Region one (1)" means the region containing Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, and McCracken Counties.

77[(76)] "Region seven (7)" means the region containing Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, and Rowan Counties.

78[(77)] "Region three (3)" means the region containing Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington Counties.

79[(78)] "Region two (2)" means the region containing Christian, Daviess, Daventry, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, and Webster Counties.

80[(79)] "Risk adjustment" means a corrective tool to reduce the negative financial consequences for a managed care organization that enrolls high-risk users and the positive financial consequences for a managed care organization that enrolls low-risk users.

81[(80)] "Rural area" means an area not in an urban area.

82[(81)] "Rural health clinic" is defined by 42 C.F.R. 405.2401(b).

83[(82)] "Specialist" means a provider who provides specialty care.

84[(83)] "Spend-down" means care or a service that is provided by a provider who is not: (a) a primary care provider; or (b) acting in the capacity of a primary care provider while providing the service.

85[(84)] "Specified low-income Medicare beneficiary" means an individual who meets the requirements established in 42 U.S.C. 1396a(a)(10)(E)(iii).

86[(85)] "State fair hearing" means an administrative hearing provided by the Cabinet for Health and Family Services pursuant to KRS Chapter 13B and 907 KAR 1:563.

87[(86)] "State plan" is defined by 42 C.F.R. 400.203.

88[(87)] "State survey agency" means the Cabinet for Health and Family Services, Office of Inspector General, Division of Health Care Facilities and Services.

89[(88)] "State survey agency" means the Cabinet for Health and Family Services pursuant to 907 KAR 1:640; with 907 KAR 1:705; nur- ners into Ma.

90[(89)] "TANF" means a block grant program established in accordance with 42 U.S.C. 1396(v).

91[(90)] "Temporary Assistance for Needy Families" or "TANF" means a block grant program which is designed to: (a) Assist needy families so that children can be cared for in their own homes; (b) Reduce the dependency of needy parents by promoting job preparation, work, and marriage; (c) Prevent out-of-wedlock pregnancies; and (d) Encourage the formation and maintenance of two-parent families.

92[(91)] "Third party liability resource" means a resource available to an enrollee for the payment of expenses: (a) Associated with the provision of covered services; and (b) That does not include amounts exempt under Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396v.

93[(92)] "Transport time" means travel time: (a) Under normal driving conditions; and (b) With no exculcating circumstances.

94[(93)] "Urban area" is defined by 42 C.F.R. 412.62(f)(1)(ii).

95[(94)] " Urgent care" means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

96[(95)] "Ward" is defined in KRS 387.510(15).

97[(96)] "Ward" is included in KRS 387.510(15).

98[(97)] "Ward" is defined by KRS 387.510(15).

99[(98)] "Ward" is defined by KRS 387.510(15).
(4)(a) Except for a child in foster care, a recipient who is eligible for enrollment into managed care shall be enrolled with an MCO that provides services to an enrollee whose primary residence is within the MCO’s service area. 
(b) A child in foster care shall be enrolled with an MCO in the county where the child’s DCBS case is located. 
(5)(a) During the department’s initial implementation of managed care in accordance with this administrative regulation, the department shall assign a recipient to an MCO based upon an algorithm that considers: 
1. Continuity of care; 
2. Enrollee preference of MCO or of an MCO provider; and 
3. Cost. 
(b) An assignment shall focus on a need of a child or an individual with a special health care need. 
(6)(a) A newly eligible recipient or a recipient who has had a break in eligibility of greater than two (2) months shall have an opportunity to choose an MCO during the eligibility application process. 
(b) If a recipient does not choose an MCO during the eligibility application process, the department shall assign the recipient to an MCO. 
(7) Each member of a household shall be assigned to the same MCO. 
(8) The effective date of enrollment for a recipient described in subsection (6) of this section shall be: 
(a) The date of Medicaid eligibility; and 
(b) No earlier than November 1, 2011. 
(9) A recipient shall be given a choice of MCOs. 
(10) A recipient enrolled with an MCO who loses Medicaid eligibility for less than two (2) months shall be automatically reenrolled with the same MCO upon redetermination of Medicaid eligibility unless the recipient moves to a county in region three (3) as established in Section 28 of this administrative regulation. 
(11) A newborn who has been deemed eligible for Medicaid shall be automatically enrolled with the newborn’s mother’s MCO as an individual enrollee for up to sixty (60) days. 
(12)(a) An enrollee may change an MCO for any reason, regardless of whether the MCO was selected by the enrollee or assigned by the department: 
1. Within ninety (90) days of the effective date of enrollment; 
2. Annually during an open enrollment period that shall be at the time of an enrollee’s recertification for Medicaid eligibility; or 
3. Annually during the month of birth for an enrollee who receives SSI benefits; 
3. Upon automatic enrollment under subsection (19)(b) of this section, if a temporary loss of Medicaid eligibility caused the recipient to lose eligibility under the annual opportunity in subparagraph 2. of this paragraph; or 
(b) An MCO shall accept an enrollee who changes MCOs under this section. 
(13) Only the department shall have the authority to enroll a Medicaid recipient with an MCO in accordance with this section. 
(14) Upon enrollment with an MCO, an enrollee shall receive two (2) identification cards. 
(a) A card shall be issued from the department that shall verify Medicaid eligibility. 
(b) A card shall be issued by the MCO that shall verify enrollment with the MCO. 
(15)(a) Within five (5) business days after receipt of notification of a new enrollee, an MCO shall send, by a method that shall not take more than three (3) days to reach the enrollee, a confirmation letter to an enrollee. 
(b) The confirmation letter shall include at least the following information: 
1. The effective date of enrollment; 
2. The name, location and contact information of the PCC; 
3. A referral; 
4. Care coordination; 
5. Benefits of preventive health care; 
6. Identification card; 
7. A member handbook; and 
8. A list of covered services. 
(16) Enrollment with an MCO shall be without restriction. 
(17) An MCO shall: 
(a) Have continuous open enrollment for new enrollees; and 
(b) Accept enrollees regardless of overall enrollment. 
(18)(a) Except as provided in paragraph (b) of this subsection, a recipient eligible to enroll with an MCO shall be enrolled beginning with the first day of the month that the enrollee applied for Medicaid. 
(b)1. A newborn shall be enrolled beginning with the newborn’s date of birth. 
2. An unemployed parent shall be enrolled beginning with the date the unemployed parent met the definition of unemployment in accordance with 45 C.F.R. 223.100. 
3. If an enrollee is retroactively determined eligible for Medicaid, the retroactive eligibility shall begin for a period up to three (3) months prior to the month that the enrollee applied for Medicaid. 
(a) The department shall be responsible for reimbursing for services provided to an individual determined to be retroactively eligible for any portion of the retroactive eligibility period which occurred prior to November 1, 2011, if the individual has a retroactive eligibility period prior to November 1, 2014. 
(b) A retroactive eligible individual’s MCO shall be responsible for reimbursing for services provided to an individual determined to be retroactively eligible for any portion of the retroactive eligibility period which occurred prior to November 1, 2011, if the individual has a retroactive eligibility period prior to November 1, 2014. 
(c) A retroactive eligible individual’s MCO shall be responsible for reimbursing for services provided to an individual determined to be retroactively eligible for any portion of the retroactive eligibility period which occurred prior to November 1, 2011, if the individual has a retroactive eligibility period prior to November 1, 2014. 
(d) A retroactive eligible individual’s MCO shall be responsible for reimbursing for services provided to an individual determined to be retroactively eligible for any portion of the retroactive eligibility period which occurred prior to November 1, 2011, if the individual has a retroactive eligibility period prior to November 1, 2014. 
(19) For an enrollee whose eligibility resulted from a successful appeal of a denial of eligibility, the enrollment period shall begin: 
(a)1. On the first day of the month of the original application for eligibility; or 
2. On the first day of the month of retroactive eligibility as referenced in subsection (18)(b)(3) of this section, if applicable; and 
(b) No earlier than November 1, 2011. 
(20) A provider shall be responsible for verifying an individual’s eligibility for Medicaid and enrollment in a managed care organization when providing a service. 

Section 3. Disenrollment. (1) The policies established in 42 C.F.R. 438.56 shall apply to an MCO. 
(2) Only the department shall have the authority to disenroll a recipient from an MCO. 
(3) A disenrollment of a recipient from an MCO shall: 
(a) Become effective on the first day of the month following determination; and 
(b) Occur: 
1. If the enrollee: 
(a) No longer resides in an area served by the MCO; 
(b) Becomes incarcerated or deceased; or 
(c) Is exempt from managed care enrollment in accordance with Section 2(3) of this administrative regulation; or 
2. In accordance with 42 C.F.R. 438.66. 
(4) An MCO may recommend to the department that an enrollee be disenrolled if the enrollee: 
(a) Is found guilty of fraud in a court of law or administratively determined to have committed fraud related to the Medicaid Program; 
(b) Is abusive or threatening but not for uncooperative or disruptive behavior resulting from his or her special needs (except if his or her continued enrollment in the MCO seriously impairs the entity’s ability to furnish services to either this particular enrollee or other enrollees) pursuant to 42 C.F.R. 438.56(b)(2); 
(c) Becomes deceased; or 
(d) No longer resides in an area served by the MCO. 
(5) An enrollee shall not be disenrolled by the department, nor shall the managed care organization recommend disenrollment of an enrollee, due to an adverse change in the enrollee’s health. 
(6)(a) An approved disenrollment shall be effective no later than the first day of the second month following the month the enrollee or the MCO files a request in accordance with 42 C.F.R. 438.56(e)(1). 
(b) If the department fails to make a determination within the timeframe specified in paragraph (a) of this subsection, the disenrollment shall be considered approved in accordance with 42 C.F.R. 438.56(e)(2).
Section 4. Enrollee Rights and Responsibilities. (1) An MCO shall have written policies and procedures:

(a) To protect the rights of an enrollee that includes:

1. Protection against liability for payment in accordance with 42 U.S.C. 1396u-2(b)(6);
2. Rights specified in 42 C.F.R. 438.100;
3. Right to prepare an advance medical directive pursuant to KRS 311.621 through KRS 311.643;
4. Right to choose and change a primary care provider;
5. Right to file a grievance or appeal;
6. Right to receive assistance in filing a grievance or appeal;
7. Right to a state fair hearing;
8. Right to a timely referral and access to medically indicated specialty care; and
9. Right to access the enrollee’s medical records in accordance with federal and state law; and
(b) Regarding the responsibilities of enrollees that include the responsibility to:

1. Become informed about:
   a. Enrollee rights specified in paragraph (a) of this subsection; and
   b. Service and treatment options;
2. Abide by the MCO’s and department’s policies and procedures;
3. Actively participate in personal health and care decisions;
4. Report suspected fraud or abuse; and
5. Keep appointments or call to cancel if unavailable to keep an appointment.
(2) The information specified in subsection (1) of this section shall meet the information requirements established in 42 C.F.R. 438.10.

Section 5. Enrollee Grievance System. (1) An MCO shall have an internal grievance system in place that allows an enrollee or a provider on behalf of an enrollee to challenge a denial of coverage or payment for a service in accordance with 42 C.F.R. 438.409 through 438.424 and 42 U.S.C. 1396u-2(b)(4).
(2) An enrollee shall have a right to a state fair hearing in accordance with KRS Chapter 13B without exhausting an MCO’s internal appeal process.
(3) An MCO shall have written policies and procedures describing how an enrollee shall submit a request for a:

(a) Grievance or an appeal with the MCO; or
(b) State fair hearing in accordance with KRS Chapter 13B.
(4) A legal guardian of an enrollee who is a minor or an incapacitated adult, a representative of an enrollee as designated in writing to an MCO, or a provider acting on behalf of an enrollee and with the enrollee’s written consent shall have the right to file a grievance or appeal on behalf of the enrollee.
(5) An enrollee shall have thirty (30) calendar days from the date of an event causing dissatisfaction to file a grievance orally or in writing with the MCO.
(6) Within five (5) working days of receipt of a grievance, an MCO shall provide the enrollee with written notice that the grievance has been received and the expected date of its resolution.
(7) An investigation and final resolution of a grievance shall:

(a) Be completed within thirty (30) calendar days of the date the grievance is received by the MCO; and
(b) Include a resolution letter to the enrollee that shall include:

1. All information considered in investigating the grievance;
2. Findings and conclusions based on the investigation; and
3. The disposition of the grievance.
(8) An enrollee shall have thirty (30) calendar days from the date of receiving a notice of adverse action from an MCO to file an appeal either orally or in writing with the MCO.
(9) A legal guardian of an enrollee who is a minor or an incapacitated adult, a representative of the enrollee as designated in writing to an MCO, or a provider acting on behalf of an enrollee with the enrollee’s written consent shall have the right to file an appeal of an adverse action on behalf of the enrollee.
(10) An MCO shall resolve an appeal within thirty (30) calendar days from the date the initial oral or written appeal is received by the MCO.
(11) An MCO shall have a process in place that ensures that an oral or written inquiry from an enrollee seeking to appeal an adverse action is treated as an appeal to establish the earliest possible filing date for the appeal.
(12) An oral appeal shall be followed by a written appeal that is signed by the enrollee within ten (10) calendar days.
(13) Within five (5) working days of receipt of an appeal, an MCO shall provide the enrollee with written notice that it has been received and the expected date of its resolution, unless an expedited resolution has been requested.
(14) An MCO shall extend the thirty (30) day timeframe for resolution of an appeal under subsection (10) of this section by fourteen (14) calendar days if:

(a) The enrollee requests the extension; or
(b) The MCO demonstrates to the department that there is need for additional information; and
2. The extension is in the enrollee’s interest.
(15) For an extension requested by an MCO, the MCO shall provide the enrollee written notice of the extension and the reason for the extension within two (2) working days of the decision to extend.
(16) For an appeal, an MCO shall provide written notice of its decision within thirty (30) calendar days to an enrollee or a provider, if the provider filed the appeal. The provider shall:

(a) Give a copy of the notice to the enrollee; or
(b) Inform the enrollee of the provisions of the notice.
(17) An MCO shall:

1. Continue to provide benefits to an enrollee, if the enrollee requested a continuation of benefits, until one of the following occurs:
   1. The enrollee withdraws the appeal;
   2. Fourteen (14) days have passed since the date of the resolution letter, if the resolution of the appeal was against the enrollee and the enrollee has not requested a state fair hearing or any further action; or
   3. A state fair hearing decision adverse to the enrollee has been issued;
   (b) Have an expedited review process for appeals if the MCO determines that allowing the time for a standard resolution could seriously jeopardize an enrollee’s life or health or ability to attain, maintain, or regain maximum function;
   (c) Resolve an expedited appeal within three (3) working days of receipt of the request; and
   (d) Extend the timeframe for an expedited appeal established in paragraph (c) of this subsection by up to fourteen (14) calendar days if:

1. The enrollee requests the extension; or
2. The MCO demonstrates to the department that there is need for additional information; and
3. The extension is in the enrollee’s interest.
(18) For an extension requested by an MCO, the MCO shall include:

(a) The enrollee requests the extension; or
(b) The MCO demonstrates to the department that there is need for additional information; and
2. The extension is in the enrollee’s interest.
(19) For an extension requested by an MCO, the MCO shall provide the enrollee written notice of the extension and the reason for the extension within two (2) working days of the decision to extend.
(20) For an appeal, an MCO shall provide written notice of its decision within thirty (30) calendar days to an enrollee or a provider, if the provider filed the appeal. The provider shall:

(a) Give a copy of the notice to the enrollee; or
(b) Inform the enrollee of the provisions of the notice.
(21) An MCO shall:

1. Continue to provide benefits to an enrollee, if the enrollee requested a continuation of benefits, until:
   1. The enrollee withdraws the appeal;
   2. Fourteen (14) days have passed since the date of the resolution letter, if the resolution of the appeal was against the enrollee and the enrollee has not requested a state fair hearing or any further action; or
   3. A state fair hearing decision adverse to the enrollee has been issued;
   (b) Have an expedited review process for appeals if the MCO determines that allowing the time for a standard resolution could seriously jeopardize an enrollee’s life or health or ability to attain, maintain, or regain maximum function;
   (c) Resolve an expedited appeal within three (3) working days of receipt of the request; and
   (d) Extend the timeframe for an expedited appeal established in paragraph (c) of this subsection by up to fourteen (14) calendar days if:

1. The enrollee requests the extension; or
2. The MCO demonstrates to the department that there is need for additional information; and
3. The extension is in the enrollee’s interest.
(22) For an extension requested by an MCO, the MCO shall provide the enrollee written notice of the extension and the reason for the extension within two (2) working days of the decision to extend.
expedited resolution and shall maintain the documentation in the enrollee case file.

(24) The department shall provide an enrollee with a hearing process that shall adhere to 907 KAR 1:563, 42 C.F.R. 438 Subpart F, and 42 C.F.R. 431 Subpart E.

(22) An enrollee shall be able to request a state fair hearing if dissatisfied with an adverse action that has been taken by an MCO:
(a) Within thirty (30) days of receiving notice of an adverse action; or
(b) Within thirty (30) days of the final decision of an MCO to an appeal filed by the enrollee.

(23) A document supporting an MCO's adverse action shall be:
(a) Received by the department no later than five (5) days from the date the MCO receives a notice from the department that a request for a state fair hearing has been filed by an enrollee; and
(b) Made available to an enrollee upon request by either the enrollee or the enrollee's legal counsel.

(24) An automatic ruling shall be made by the department in favor of an enrollee if an MCO fails to:
(a) Comply with the state fair hearing requirements established by the state and federal Medicaid law; or
(b) Appear in person and present evidence at the state fair hearing.

(25) An MCO shall:
(a) Provide information specified in 42 C.F.R. 438.10(g)(1) about the grievance system to a service provider and a subcontractor at the time they enter into a contract;
(b) Maintain a grievance or an appeal file in a secure and designated area;
(c) Make a grievance or an appeal file accessible to the department or its designee upon request;
(d) Retain a grievance or an appeal file for ten (10) years following a final decision by the MCO, the department, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later;
(e) Have procedures for assuring that a grievance or an appeal file contains:
1. Information to identify the grievance or appeal;
2. The date a grievance or appeal was received;
3. The nature of the grievance or appeal;
4. A notice to the enrollee of receipt of the grievance or appeal; and
5. Correspondence between the MCO and the enrollee;
6. The date the grievance or appeal is resolved;
7. The decision made by the MCO of the grievance or appeal;
8. The notice of a final decision to the enrollee; and
9. Information concerning the grievance or appeal, and (f) Make available to an enrollee documentation regarding a grievance or an appeal.

(26) An MCO shall designate an individual to:
(a) Execute the policies and procedures for resolution of a grievance or appeal;
(b) Review patterns or trends in grievances or appeals; and
(c) Initiate a corrective action, if needed.

Section 6. Member Services. (1) An MCO shall have a member services function that includes a member call center and a behavioral health call center that shall:
(a) Be staffed Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Time; and
(b) Meet the call center standards, which shall:
1. Be approved by the American Accreditation Health Care Commission or Utilization Review Accreditation Committee (URAC); and
2. Include provisions addressing the call center abandonment rate, blockage rate and average speed of answer.

(22) An MCO shall provide medical advice to an enrollee through a toll-free call-in system, available twenty-four hours a day, seven (7) days a week.
(b) The call-in system shall be staffed by medical professionals to include:
1. Physicians;
2. Physician assistants;
3. Licensed practical nurses; or
4. Registered nurses.

(3) An enrollee may:
(a) Provide foreign language interpreter services, free of charge, for an enrollee;
(b) Respond to the special communication needs of the disabled, blind, deaf, or aged;
(c) Facilitate direct access to a specialty physician for an enrollee:
1. With a chronic or complex health condition;
2. Who is aged, blind, deaf, or disabled; or
3. Identified as having a special healthcare need and requiring a course of treatment or regular healthcare monitoring.
(d) Arrange for and assist with scheduling an EPSDT service in conformance with federal law governing EPSDT;
(e) Provide an enrollee with information or refer the enrollee to a support service;
(f) Facilitate direct access to a covered service in accordance with Section 29(4) of this administrative regulation.
(g) Facilitate access to a:
1. Behavioral health service;
2. Pharmaceutical service; or
3. Service provided by a public health department, community mental health center, rural health clinic, federally qualified health center, the Commission for Children with Special Health Care Needs, or a charitable care provider;
(h) Assist an enrollee in:
1. Scheduling an appointment with a provider;
2. Obtaining transportation for an emergency or non-emergency service;
3. Completing a health risk assessment; or
4. Accessing an MCO health education program;
(i) Process, record, and track an enrollee grievance and appeal; and
(j) Refer an enrollee to case management or disease management.

Section 7. Enrollee Selection of Primary Care Provider. (1) Except for an enrollee described in subsection (2) of this section, an MCO shall have a process for enrollee selection and assignment of a primary care provider.

(2) The following shall not be required to have a primary care provider:
(a) A dual eligible;
(b) A child in foster care;
(c) A child under the age of eighteen (18) years who is disabled; or
(d) A pregnant woman who is presumptively eligible pursuant to 907 KAR 1:810.

(3) (a) An enrollee who is not receiving supplemental security income benefits:
1. An MCO shall notify the enrollee within ten (10) days of notification of enrollment by the department of the procedure for choosing a primary care provider; and
2. If the enrollee does not choose a primary care provider, an MCO shall assign to the enrollee a primary care provider who:
(a) Has historically provided services to the enrollee; and
(b) Meets the requirements of subsection (6) of this section.

(2) If no primary care provider meets the requirements of paragraph (a) of this subsection, an MCO shall assign an enrollee to a primary care provider who is:
(a) Thirty (30) miles or thirty (30) minutes from the enrollee’s residence or place of employment if the enrollee is in a rural area; or
(b) Forty-five (45) miles or forty-five (45) minutes from the enrollee’s residence or place of employment if the enrollee is in an urban area.

(4) (a) An enrollee who is receiving supplemental security income benefits and is not a dual eligible, an MCO shall notify the enrollee of the procedure for choosing a primary care provider.
(b) If an enrollee has not chosen a primary care provider within thirty (30) days, an MCO shall send a second notice to the enrollee.
(c) If an enrollee has not chosen a primary care provider within thirty (30) days of the second notice, the MCO shall send a third notice to the enrollee.

(d) If an enrollee has not chosen a primary care provider after the third notice, the MCO shall assign a primary care provider.

(e) Except for an enrollee who was previously enrolled with the MCO, an MCO shall not automatically assign a primary care provider within ninety (90) days of the enrollee’s initial enrollment.

(5)(a) An enrollee shall be allowed to select from at least two (2) primary care providers within an MCO’s provider network.

(b) At least one (1) of the two (2) primary care providers referred to in paragraph (a) of this subsection shall be a physician.

(c) A primary care provider shall:

1. Be a licensed or certified health care practitioner who functions within the provider’s scope of licensure or certification, including:
   1. A physician;
   2. An advanced practice registered nurse;
   3. A registered nurse;
   4. A clinic, including a primary care center, federally qualified health center, or rural health clinic;

2. Have admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges.

(c) Agree to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to enrollees; and

(d) For an enrollee who has a gynecological or obstetrical health care need, a disability, or chronic illness, be a specialist who agrees to provide or arrange for primary and preventive care directly or through linkage with a primary care provider.

(7) Upon enrollment in an MCO, an enrollee shall have the right to change primary care providers:

(a) Within the first ninety (90) days of assignment;

(b) Once a year regardless of reason;

(c) At any time for a reason approved by the MCO;

(d) If during a temporary loss of eligibility, an enrollee loses the opportunity provided by paragraph (b) of this subsection;

(e) If Medicare or Medicaid imposes a sanction on the PCP;

(f) If the PCP is no longer in the MCO provider network; or

(g) At any time with cause which shall include the enrollee:
   1. Receiving poor quality of care;
   2. Lacking access to providers qualified to treat the enrollee’s medical condition;
   3. Being denied access to needed medical services.

(b) A PCP shall not be able to request the reassignment of an enrollee to a different PCP for the following reasons:

(a) A change in the enrollee’s health status or treatment needs;

(b) An enrollee’s utilization of health services;

(c) An enrollee’s diminished mental capacity;

(d) Disruptive behavior of an enrollee due to the enrollee’s special health care needs unless the behavior impairs the PCP’s ability to provide services to the enrollee or others.

(9) A PCP change request shall not be based on race, color, national origin, disability, age, or gender.

(10) An MCO shall have the authority to approve or deny a primary care provider change.

(11) An enrollee shall be able to obtain the following services outside of an MCO’s provider network:

(a) A family planning service in accordance with 42 C.F.R. 431.51;

(b) An emergency service in accordance with 42 C.F.R. 438.114;

(c) A post-stabilization service in accordance with 42 C.F.R. 438.114 and 42 C.F.R. 422.113(c); or

(d) An out-of-network service that an MCO is unable to provide within its network to meet the medical need of the enrollee in accordance with 42 C.F.R. 438.206(b)(4).

(12) An MCO shall:

(a) Notify an enrollee within:

1. Thirty (30) days of the effective date of a voluntary termination of the enrollee’s primary care provider; or

2. Fifteen (15) days of an involuntary termination of the enrollee’s primary care provider; and

(b) Assist the enrollee in selecting a new primary care provider.

Section 8. Primary Care Provider Responsibilities. (1) A PCP shall:

(a) Maintain:
   1. Continuity of an enrollee’s health care;
   2. A current medical record for an enrollee in accordance with Section 24 of this administrative regulation; and

3. Formalized relationships with other PCPs to refer enrollees for after-hours care, during certain days, for certain services, or other reasons to extend their practice;

(b) Refer an enrollee for specialty care or other medically necessary services, both in and out of network, if the services are not available within the MCO’s network;

(c) Discuss advance medical directives with an enrollee;

(d) Provide primary and preventive care, including EPSDT services;

(e) Refer an enrollee for a behavioral health service if clinically indicated; and

(f) Have an after-hours phone arrangement that ensures that a designated medical practitioner returns the call within thirty (30) minutes.

(2) An MCO shall monitor a PCP to ensure compliance with the requirements established in this section.

Section 9. Member Handbook. (1) An MCO shall:

(a) Send a member handbook to an enrollee, by a method that shall not take more than three (3) days to reach the enrollee, within five (5) business days of enrollment;

(b) Review the member handbook at least annually;

(c) Communicate a change to the member handbook to an enrollee in writing; and

(d) Add a revision date to the member handbook after revising the member handbook.

(2) A member handbook shall:

(a) Be available:
   1. In hardcopy in English, Spanish, and any other language spoken by at least five (5) percent of the potential enrollee or enrollee population; and
   2. On the MCO’s Web site;

(b) Be written at no higher than a sixth grade reading comprehension level; and

(c) Include at a minimum the following information:
   1. The MCO’s network of primary care providers, including the names, telephone numbers, and service site addresses of available primary care providers, and, if desired by the MCO, the names and contact information for other providers included in the MCO’s network;

2. The procedures for:
   a. Selecting a PCP and scheduling an initial health appointment;

   b. Obtaining:
      (i) Emergency or non-emergency care after hours;
      (ii) Transportation for emergency or non-emergency care;
      (iii) An EPSDT service;

   c. A covered service from an out-of-network provider; or

   d. A long term care service;

   e. Notifying DCBS of a change in family size or address, a birth or a death of an enrollee;

   f. Selecting or requesting to change a PCP;

   g. A reason a request for a change may be denied by the MCO;

   h. A reason a provider may request to transfer an enrollee to a different PCP, and

   i. Filing a grievance or appeal, including the title, address, and telephone number of the person responsible for processing and resolving a grievance or appeal;

   2. The name of the MCO, address, and telephone number from which it conducts its business;

   a. Business hours; and

   b. Member service and toll-free medical call-in telephone numbers;

   5. Covered services, an explanation of any service limitation or exclusion from coverage, and a notice stating that the MCO shall be liable only for those services authorized by the MCO, except for
the services excluded in Section 7(11) of this administrative regulation;
6. Member rights and responsibilities;
7. For a life-threatening situation, instructions to use the emergency medical services available or to activate emergency medical services by dialing 911;
8. Information on:
   a. The availability of maternity and family planning services, and for the prevention and treatment of sexually transmitted diseases;
   b. Accessing the services referenced in clause a. of this paragraph;
   c. Accessing care before a primary care provider is assigned or chosen;
   d. The Cabinet for Health and Family Services’ independent ombudsman program; and
   e. The availability of, and procedures for, obtaining:
      (i) A behavioral health or substance abuse service;
      (ii) A health education service; and
      (iii) Care coordination, case management, and disease management services;
9. Direct access services that may be accessed without a referral; and
10. An enrollee’s right to obtain a second opinion and information on obtaining a second opinion; and
11. Meet the information requirements established in Section 12 of this administrative regulation.
(3) Changes to the member handbook shall be approved by the department prior to the publication of the handbook.

Section 10. Member Education and Outreach. (1) An MCO shall:
   (a) Have an enrollee and community education and outreach program throughout the MCO’s service area; and
   (b) Submit an annual outreach plan to the department for approval.
   (c) Assess the homeless population within its service area by implementing and maintaining an outreach program for homeless individuals, including victims of domestic violence; and
   (d) Not differentiate between a service provided to an enrollee who is homeless and an enrollee who is not homeless.
(2) An MCO’s outreach plan shall include:
   (a) Utilizing existing community resources, including shelters and clinics; and
   (b) Face-to-face encounters.

Section 11. Enrollee Non-Liability for Payment. (1) Except as specified in Section 59 of this administrative regulation, an enrollee shall not be required to pay for a medically necessary covered service provided by the enrollee’s MCO.
   (2) An MCO shall not impose cost sharing on an enrollee greater than the limits established by the department in 907 KAR 1:604.
   (3) If an enrollee agrees, in advance and in writing, to pay for a non-Medicaid covered service, the provider of the service shall be authorized to bill the enrollee for the service.

Section 12. Provision of Information Requirements. (1) An MCO shall:
   (a) Comply with the requirements established in 42 U.S.C. 4096a-2(a)(5) and 42 C.F.R. 438.10; and
   (b) Provide translation services to an enrollee on site or via telephone.
   (2) Written material provided by an MCO to an enrollee or potential enrollee shall:
      (a) Be written at a sixth-grade reading comprehension level;
      (b) Be published in at least a twelve (12) point font;
      (c) Comply with the requirements established in 42 U.S.C. Chapter 126, the Americans with Disabilities Act;
      (d) Be updated as necessary to maintain accuracy;
      (e) Be available in Braille or in an audio format for an individual who is partially blind or blind; and
      (f) Be provided and printed in each language spoken by five (5) percent or more of the enrollees in each county.
   (3) All written material intended for an enrollee, unless unique to an individual enrollee or exempted by the department, shall be submitted to the department for review and approval prior to publication or distribution to the enrollee.

Section 13. Provider Services. (1) An MCO shall have a provider services function responsible for:
   (a) Enrolling, credentialing, recredentialing, and evaluating a provider;
   (b) Assisting a provider with an inquiry regarding enrollee status, prior authorization, referral, claim submission, or payment;
   (c) Informing a provider of the provider’s rights and responsibilities;
   (d) Handling, recording, and tracking a provider grievance and appeal;
   (e) Developing, distributing, and maintaining a provider manual;
   (f) Provider orientation and training, including:
      1. Medicaid covered services;
      2. EPSDT coverage;
      3. Medicaid policies and procedures;
      4. MCO policies and procedures; and
      5. Fraud, waste, and abuse;
   (g) Assisting in coordinating care for a child or adult with a complex or chronic condition;
   (h) Assisting a provider with enrolling in the Vaccines for Children Program in accordance with 907 KAR 1:680; and
   (i) Providing technical support to a provider regarding the provision of a service.
   (2) An MCO’s provider services staff shall:
      (a) Be available at a minimum Monday through Friday from 8:00 a.m. to 6:00 p.m. Eastern Time; and
      (b) Operate a provider call center.

Section 14. Provider Network. (1) An MCO shall:
   (a) Enroll providers of sufficient types, numbers, and specialties in its network to satisfy the.
      1. Access and capacity requirements established in Section 15 of this administrative regulation; and
      2. Quality requirements established in Section 48 of this administrative regulation;
   (b) Attempt to enroll the following providers in its network:
      1. A teaching hospital;
      2. A rural health clinic; and
      3. The Kentucky Commission for Children with Special Health Care Needs;
   (c) A local health department; and
   (d) A community mental health center;
   (e) Demonstrate to the department the extent to which it has enrolled providers in its network who have traditionally provided services to Medicaid recipients;
   (f) Have at least one (1) FQHC in a region where the MCO operates in accordance with Section 28 of this administrative regulation, if there is an FQHC that is licensed to provide services in the region; and
   (g) Exclude, terminate, or suspend from its network a provider or subcontractor who engages in an activity that results in suspension, termination, or exclusion from the Medicare or a Medicaid program.
   (2) The length of an exclusion, termination, or suspension referenced in subsection (1)(e) of this section shall equal the length of the exclusion, termination, or suspension imposed by the Medicare or a Medicaid program.
   (3) If an MCO is unable to enroll a provider specified in subsection (1)(b) or (c) of this section, the MCO shall submit to the department for approval, documentation which supports the MCO’s conclusion that adequate services and service sites as required in Section 15 of this administrative regulation shall be provided without enrolling the specified provider.
   (4) If an MCO determines that its provider network is inadequate to comply with the access standards established in Section 15 of this administrative regulation, the MCO shall:
      (a) Notify the department; and
      (b) Submit a corrective action plan to the department.
(5) A corrective action plan referenced in subsection (4)(b) of this section shall:
(a) Describe the deficiency in detail; and
(b) Identify a specific action to be taken by the MCO to correct the deficiency, including a time frame.

Section 15. Provider Access Requirements. (1) The access standards requirements established in 42 C.F.R. 438.206 through 438.210 shall apply to an MCO.

(2) An MCO shall make available and accessible to an enrollee:
(a) Facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section;
(b) Emergency medical services twenty-four (24) hours a day, seven (7) days a week; and
(c) Urgent care services within forty-eight (48) hours of request.

(3)(a) An MCO’s primary care provider delivery site shall be no more than:
1. Thirty (30) miles or thirty (30) minutes from an enrollee’s residence or place of employment in an urban area; or
2. Forty-five (45) miles or forty-five (45) minutes from an enrollee’s residence or place of employment in a non-urban area.

(b) An MCO’s primary care provider shall not have an enrollee to primary care provider ratio greater than 1:500:1.

(4)(a) An appointment wait time at an MCO’s primary care delivery site shall not exceed:
1. Thirty (30) days from the date of an enrollee’s request for a routine or preventive service; or
2. Forty-eight (48) hours from an enrollee’s request for urgent care.

(b) A dental appointment wait time shall not exceed:
1. Three (3) weeks for a regular appointment; or
2. Forty-eight (48) hours for urgent care.

(5)(a) Transport time to a general vision, laboratory, or radiological service shall not exceed one (1) hour from an enrollee’s residence.

(b) Transport time to a pharmacy service shall not exceed one (1) hour from an enrollee’s residence.

(c) Transport time or distance threshold shall not apply to a mail order pharmacy except that it shall:
1. Be physically located within the United States of America; and
2. Provide delivery to the enrollee’s residence.

(6) An emergency service shall be provided at a health care facility most suitable for the type of injury, illness, or condition, who are less than twenty-one (21) years of age.

(7)(a) Except as provided in paragraph (b) of this subsection, an enrollee’s transport time to a hospital shall not exceed thirty (30) minutes from an enrollee’s residence.

(b) Medically necessary;
1. An appointment wait time at an MCO’s primary care delivery site shall not exceed:
1. Thirty (30) miles or thirty (30) minutes from an enrollee’s residence or place of employment in an urban area; or
2. Forty-five (45) miles or forty-five (45) minutes from an enrollee’s residence or place of employment in a non-urban area.

(c) An appointment wait time at an MCO’s primary care delivery site shall not exceed:
1. Thirty (30) days from the date of an enrollee’s request for a routine or preventive service; or
2. Forty-eight (48) hours from an enrollee’s request for urgent care.

(d) An appointment wait time for a specialist, except for a specialist providing a behavioral health service as provided in paragraph (b) of this subsection, shall not exceed:
1. Three (3) weeks for a regular appointment; or
2. Forty-eight (48) hours for urgent care.

(e) A dental appointment wait time shall not exceed:
1. Three (3) weeks for a regular appointment; or
2. Forty-eight (48) hours for urgent care.

(f) An appointment wait time for a specialist, except for a specialist providing a behavioral health service, requiring crisis stabilization shall be provided within twenty-four (24) hours of the referral.

(g) A behavioral health service requiring crisis stabilization shall be provided within twenty-four (24) hours of the referral.

(h) Behavioral health urgent care shall be provided within forty-eight (48) hours of the referral.

(i) Behavioral health urgent service appointment following a discharge from an acute psychiatric hospital shall occur within fourteen (14) days of discharge.

(j) A behavioral health service appointment not included in subparagraph 1, 2, or 3 of this paragraph shall occur within sixty (60) days of the referral.

(8) An MCO shall have:
1. Sufficient pediatric specialists available for the subpopulations designated in Section 30 of this administrative regulation; and
2. A sufficient pediatric specialists to meet the needs of enrollees who are less than twenty-one (21) years of age.

(9)(a) An emergency service shall be provided at a health care facility most suitable for the type of injury, illness, or condition, whether or not the facility is in the MCO network.

(b) An enrollee’s transport time to a hospital shall not exceed thirty (30) minutes from an enrollee’s residence.

(c) A pharmacy delivery site, except for a mail order pharmacy, shall not be further than fifty (50) miles from an enrollee’s residence.

(d) An appointment wait time for a specialist, except for a specialist providing a behavioral health service, requiring crisis stabilization shall be provided within twenty-four (24) hours of the referral.

(e) An appointment wait time for a specialist, except for a specialist providing a behavioral health service, requiring crisis stabilization shall be provided within twenty-four (24) hours of the referral.

(f) The reporting of communicable diseases.

(g) The MCO’s QAPI program as referenced in Section 48 of this administrative regulation:
1. Medical records;
2. The external quality review organization; and
3. The rights and responsibilities of enrollees and providers; and
4. Ensure that a provider:
1. Is informed of an update on a federal, state, or contractual requirement;
2. Receives education on a finding from its QAPI program if deemed necessary by the MCO or department; and
3. Makes available to the department training attendance rosters that shall be dated and signed by the attendees.

Section 16. Provider Manual. (1) An MCO shall provide a provider manual to a provider within five (5) working days of enrollment with the MCO.

(2) Prior to distributing a provider manual or update to a provider manual, an MCO shall procure the department’s approval of the provider manual or provider manual update.

(3) The provider manual shall be available in hard copy and on the MCO’s website.

Section 17. Provider Orientation and Education. An MCO shall:
1. Conduct an initial orientation for a provider within thirty (30) days of enrollment with the MCO to include:
(a) Medicaid coverage policies and procedures;
(b) Reporting fraud and abuse;
(c) Medicaid eligibility groups;
(d) The standards for preventive health services;
(e) The special needs of enrollees;
(f) Advance medical directives;
(g) EPSDT services;
(h) Claims submission;
(i) Care management or disease management programs available to enrollees;
(j) Cultural sensitivity;
(k) The needs of enrollees with mental, developmental, or physical disabilities;
(l) The reporting of communicable diseases;
(m) The MCO’s QAPI program as referenced in Section 48 of this administrative regulation;
(n) Medical records;
(o) The external quality review organization; and
(p) The rights and responsibilities of enrollees and providers; and
2. Ensure that a provider:
(a) Is informed of an update on a federal, state, or contractual requirement;
(b) Receives education on a finding from its QAPI program if deemed necessary by the MCO or department; and
(c) Makes available to the department training attendance rosters that shall be dated and signed by the attendees.

Section 18. Provider Credentialing and Recredentialing. (1) An MCO shall:
(a) Have policies and procedures that comply with 907 KAR 1:672, KRS 205.560, regarding the credentialing and recredentialing of a provider;
(b) Have a process for verifying a provider’s credentials and malpractice insurance that shall include:
1. Written policies and procedures for credentialing and recredentialing of a provider;
2. A governing body, or a group or individual to whom the governing body has formally delegated the credentialing function; and
3. A review of the credentialing policies and procedures by the governing body or its delegate;
(c) Have a credentialing committee that makes recommendations regarding credentialing;
(d) If a provider requires a review by the credentialing committee, based on the MCO’s quality criteria, notify the department of the facts and outcomes of the review;
(a) Have written policies and procedures for:
1. Excluding, terminating, or suspending a provider; and
2. Reporting a quality deficiency that results in an exclusion, suspension, or termination of a provider;
(f) Document its monitoring of a provider;
(g) Verify a provider’s qualifications through a primary source that includes:
1. A current valid license or certificate to practice in the Commonwealth of Kentucky;
2. A Drug Enforcement Administration certificate and number, if applicable;
3. If a provider is not board-certified, proof of graduation from a medical school and completion of a residency program;
4. Proof of completion of an accredited nursing, dental, physician assistant, or vision program, if applicable;
5. A provider states on an application that the provider is board certified in a specialty, a professional board certification;
6. A previous five (5) year work history;
7. A professional liability claims history;
8. If a provider requires access to a hospital to practice, proof that the provider has clinical privileges and is in good standing at the hospital designated by the provider as the primary admitting hospital;
9. Malpractice insurance;
10. Documentation, if applicable, of a:
   a. Revocation, suspension, or probation of a state license or Drug Enforcement Agency certificate and number;
   b. Curtailment or suspension of a medical staff privilege;
   c. Sanction or penalty imposed by the United States Department of Health and Human Services or a state Medicaid agency;
   d. Censure by a state or county professional association; and
   e. The most recent provider information available from the National Practitioner Data Bank;
(h) Obtain access to the National Practitioner Data Bank as part of its credentialing process;
(i) Have:
   1. A process to recredential a provider at least once every two years, i.e., shall be in accordance with subsection (3) of this section; and
   2. Procedures for monitoring a provider sanction, a complaint, or a quality issue between a recredentialing cycle;
(j) Have or obtain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line within four (4) years of implementation of this administrative regulation; and
(k) Continuously maintain NCQA accreditation for its Medicaid product line after obtaining the accreditation.
(2) If an MCO subcontracts a credentialing or recredentialing function, the MCO and the subcontractor shall have written policies and procedures for credentialing and recredentialing.
(3) A provider shall complete a credentialing application, in accordance with 907 KAR 1:672, that includes a statement by the provider regarding:
(a) The provider’s ability to perform essential functions of a position, with or without accommodation;
(b) The provider’s lack of current illegal drug use;
(c) The provider’s history of:
   1. Loss of license or a felony conviction;
   2. Loss or limitation of a privilege; or
   3. Disciplinary action;
(d) A sanction, suspension, or termination by the United States Department of Health and Human Services or a state Medicaid agency;
(e) Clinical privileges and standing at a hospital designated as the primary admitting hospital of the provider;
(f) Malpractice insurance maintained by the provider; and
(g) The correctness and completeness of the application.
(4) The department shall be responsible for credentialing and recredentialing a hospital-based provider.

Section 19. MCO Provider Enrollment. (1) A provider enrolled with an MCO shall:
(a) Be credentialed by the MCO in accordance with the standards established in Section 18 of this administrative regulation; and
(b) Be eligible to enroll with the Kentucky Medicaid Program in accordance with 907 KAR 1:672.
(2) An MCO shall:
(a) Not enroll a provider in its network if:
   1. The provider has an active sanction imposed by the Centers for Medicare and Medicaid Services or a state Medicaid agency;
   2. A required provider license or a certification is not current;
   3. Based on information or records available to the MCO:
   a. The provider owes money to the Kentucky Medicaid program;
   b. The Kentucky Office of the Attorney General has an active fraud investigation of the provider; or
   c. The provider is not credentialed;
   (b) Have and maintain documentation regarding a provider’s qualifications and procedures for monitoring a provider sanction, a complaint, or an exclusion, termination, or suspension of a provider; and
   (c) Keep the documentation referenced in paragraph (b) of this subsection available for review by the department.
(3) (a) A provider shall not be required to participate in Kentucky Medicaid fee-for-service to enroll with an MCO.
   (b) If a provider is not a participant in Kentucky Medicaid fee-for-service, the provider shall obtain a Medicaid provider number from the department in accordance with 907 KAR 1:672.

Section 20. Provider Discrimination. An MCO shall:
(1) Comply with the antidiscrimination requirements established in:
   (a) 42 U.S.C. 1396u-2(b)(7);
   (b) 42 C.F.R. 438.12; and
   (c) KRS 304.17A.270; and
(2) Provide written notice to a provider denied participation in the MCO’s network stating the reason for the denial.

Section 21. Release for Ethical Reasons. An MCO shall:
(1) Not require a provider to perform a treatment or procedure that is contrary to the provider’s conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. 438.102;
(2) Not prohibit or restrict a provider from advising an enrollee about health status, medical care, or a treatment:
   (a) Whether or not coverage is provided by the MCO; and
   (b) If the provider is acting within the lawful scope of practice; and
(3) Have a referral process in place if a provider declines to perform a service because of an ethical reason.

Section 22. Provider Grievances and Appeals. (1) An MCO shall have written policies and procedures for the filing of a provider grievance or appeal:
(2) A provider shall have the right to file:
   (a) A grievance with an MCO; or
   (b) An appeal with an MCO regarding:
      1. A provider payment issue; or
      2. A contractual issue;
   (3)(a) A provider grievance or appeal shall be resolved within thirty (30) calendar days.
   (b) If a grievance or appeal is not resolved within thirty (30) days, an MCO shall request a fourteen (14) day extension from the provider. The provider shall approve the extension or request a new extension from the provider.
   (c) If a provider requests an extension, the MCO shall approve the extension.

Section 23. Cost Reporting Information. The department shall provide to the MCO the calculation of Medicaid allowable costs as used in the Medicaid Program.

Section 24. Medical Records. (1) An MCO shall:
(a) Require a provider to maintain an enrollee medical record on paper or in an electronic format; and
(b) Have a process to systematically review provider medical records to ensure compliance with the medical records standards established in this section.

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(2) An enrollee medical record shall:
   (a) Be legible, current, detailed, organized, and signed by the
   service provider;
   (b) Be kept for at least five (5) years from the date of service
   unless a federal statute or regulation requires a longer retention
   period; and
   (c) Include the following minimal detail for an individual clinical
   encounter:
      1. The history and physical examination for the presenting
         complaint;
      2. A psychological or social factor affecting the patient’s physi-
         cal or behavioral health;
      3. An unresolved problem, referral, or result from a diagnostic
         test; and
      4. The plan of treatment including:
         a. Medication history; medications prescribed, including the
            strength, amount, and directions for use and refills;
         b. Therapy or other prescribed regimen; and
         c. Follow-up plans, including consultation, referrals, and return
            appointment.
   (3) A medical chart organization and documentation shall, at a
      minimum, contain the following:
   (a) Enrollee identification information on each page;
   (b) Enrollee date of birth, age, gender, marital status, race or
       ethnicity, mailing address, home and work addresses, and tele-
       phone numbers (if applicable), employer (if applicable), school (if
       applicable), name and telephone number of an emergency contact,
       consent form, language spoken, and guardianship information (if
       applicable);
   (c) Date of entry and of the encounter;
   (d) Provider’s name;
   (e) Any known allergies or adverse reactions of the enrollee;
   (f) Enrollee’s past medical history;
   (g) Identification of any current problem;
   (h) If a consultation, laboratory, or radiology report is filed in
      the medical record, the ordering provider’s initials or other doc-
      umentation indicating review;
   (i) Documentation of immunizations;
   (j) Identification and history of nicotine, alcohol use, or sub-
       stance abuse;
   (k) Documentation of notification of reportable diseases and
       conditions to the local health department serving the jurisdiction
       in which the enrollee resides or to the Department for Public Health
       pursuant to 902 KAR 2:020;
   (l) Follow-up visits provided secondary to reports of emergency
       room care;
   (m) Hospital discharge summaries;
   (n) Advance medical directives for adults; and
   (o) All written denials of service and the reason for each denial.

Section 25. Confidentiality of Medical Information. (1) An MCO
shall:
   (a) Maintain confidentiality of all enrollee eligibility information
       and medical records;
   (b) Prevent unauthorized disclosure of the information refe-
       renced in this subsection in accordance with KRS 194A.060, KRS
       214.188, KRS 434.840 to 434.860, and 42 C.F.R. 431 Subpart F,
       431.200 to 431.202;
   (c) Have written policies and procedures for maintaining the
       confidentiality of enrollee records;
   (d) Comply with 42 U.S.C. 1320d-2, the Health Insurance Por-
       tability and Accountability Act, and 45 C.F.R. Parts 160 and 164;
   (a) On behalf of its employees and agents:
      1. Sign a confidentiality agreement attesting that it will comply
         with the confidentiality requirements established in this section;
      2. Submit the confidentiality agreement referenced in subpara-
         graph (1) of this paragraph to the department;
       (f) Limit access to medical information to a person or agency
           which requires the information in order to perform a duty related
           to the department’s administration of the Medicaid program, including
           the department, the United States Department of Health and Hu-
           man Services, the United States Attorney General, the CHFS OIG,
           the Kentucky Attorney General, or other agency required by the
           department; and
   (g) Submit a request for disclosure of information referenced in
       this subsection which has been received by the MCO to the de-
       partment within twenty-four (24) hours.
   (2) Information referenced in subsection (1)(g) of this section
shall not be disclosed by an MCO pursuant to the request without
prior written authorization from the department.

Section 26. Americans with Disabilities Act and Cabinet Omb-
udeman. (1) An MCO shall:
   (a) Require by contract with its network providers and subco-
trators that a service location meets:
      1. The requirements established in 42 U.S.C. Chapter 126, the
         Americans with Disabilities Act; and
      2. All local requirements which apply to health facilities pertai-
         ning to adequate space, supplies, sanitation, and fire and safety
         procedures;
   (b) Fully cooperate with the Cabinet for Health and Family
      Services independent ombudman; and
6. Provide immediate access, to the Cabinet for Health and
      Family Services independent ombudman, to an enrollee’s records
      if the enrollee has given consent
   (c) Not send or face-to-face marketing;
   (d) Not use fraudulent, misleading, or misrepresentative infor-
       mation in its marketing materials;
   (e) Not offer material or financial gain to a:
      1. Potential enrollee as an inducement to select a particular
         provider or use a product; or
      2. Person for the purpose of soliciting, referring, or otherwise
         facilitating the enrollment of an enrollee;
   (f) Not conduct:
      1. Direct telephone marketing to enrollees or potential enrol-
         lees who do not reside in the MCO service area; or
      2. Direct or indirect door to door, telephone, or other cold call
         marketing activity; and
   (g) Not include in its marketing materials an assertion or state-
      ment that CMS, the federal government, the Commonwealth, or
      another entity endorses the MCO.
   (2) An MCO’s marketing material shall meet the information
      requirements established in Section 12 of this administrative regu-
      lation.

Section 27. Marketing. (1) An MCO shall:
   (a) Comply with the requirements established in 42 C.F.R.
       438.104 regarding marketing activities;
   (b) Have a system of control over the content, form, and me-
       thod of dissemination of its marketing and information materials;
   (c) Submit a marketing plan and marketing materials to the
       department for written approval prior to implementation or distribu-
       tion;
   (d) If conducting mass media marketing, direct the marketing
       activities to enrollees in the entire service area pursuant to the
       marketing plan;
   (e) Not send or face-to-face marketing;
   (f) Not use fraudulent, misleading, or misrepresentative infor-
       mation in its marketing materials;
   (g) Not offer material or financial gain to a:
      1. Potential enrollee as an inducement to select a particular
         provider or use a product; or
      2. Person for the purpose of soliciting, referring, or otherwise
         facilitating the enrollment of an enrollee;
   (h) Not conduct:
      1. Direct telephone marketing to enrollees or potential enrol-
         lees who do not reside in the MCO service area; or
      2. Direct or indirect door to door, telephone, or other cold call
         marketing activity; and
   (i) Not include in its marketing materials an assertion or state-
      ment that CMS, the federal government, the Commonwealth, or
      another entity endorses the MCO.
   (2) An MCO’s marketing material shall meet the information
      requirements established in Section 12 of this administrative regu-
      lation.

Section 28. MCO Service Areas. (1)(a) An MCO’s service area
shall include regions one (1), two (2), four (4), five (5), six
(6), seven (7), and eight (8).
   (b) An MCO’s service area shall not include region three (3).
   (2) A recipient who is eligible for enrollment with a managed
      care organization and who resides in region three (3) shall receive
      services in accordance with 907 KAR 1:705.
   (3) Region one (1) shall include the following counties:
      (a) Ballard;
      (b) Caldwell;
      (c) Calloway;
      (d) Carlisle;
      (e) Crittenden;
      (f) Fulton;
Section 29. Covered Services. (1) Except as established in subsection (2) of this section, an MCO shall be responsible for the provision and costs of a covered health service:

(a) Established in Title 907 of the Kentucky Administrative Regulations;

(b) In the amount, duration, and scope that the services are covered for recipients pursuant to the department's administrative regulations located in Title 907 of the Kentucky Administrative Regulations; and

(c) Beginning on the date of enrollment of a recipient into the MCO.

(2) Other than a nursing facility cost referenced in subsection (3)(i) of this section, an MCO shall be responsible for the cost of a nonnursing facility covered service provided to an enrollee during the first thirty (30) days of a nursing facility admission in accordance with this administrative regulation.

(3) An MCO shall not be responsible for the provision or costs of the following:

(a) A service provided to a recipient in an intermediate care facility for individuals with mental retardation or a developmental disability;

(b) A service provided to a recipient in a 1915(c) home and community-based waiver program;

(c) A hospice service provided to a recipient in an institution;

(d) A nonemergency transportation service provided in accordance with 907 KAR 3:066.
(a) Except as established in Section 35 of this administrative regulation, a school-based health service;
(b) A service not covered by the Kentucky Medicaid program;
(c) A health access-nurturing-developing service pursuant to 907 KAR 3:140;
(d) An early intervention program service pursuant to 907 KAR 1:720 or
(i). A nursing facility service for an enrollee during the first thirty (30) days of a nursing facility admission.
4. The following covered services provided by an MCO shall be accessible to an enrollee without a referral from the enrollee’s primary-care provider:
(a) A primary care vision service;
(b) A primary dental or oral surgery service;
(c) An evaluation by an orthodontist or a prosthodontist;
(d) A service provided by a women’s health specialist;
(e) A family-planning service;
(f) An emergency service;
(g) A material for an enrollee under age eighteen (18);
(h) An immunization for an enrollee under twenty-one (21);
(i) A screening, evaluation, or treatment service for a sexually transmitted disease or tuberculosis;
(j) Testing for HIV, HIV-related condition, or other communicable disease; and
(k) A chiropractic service.
5. An MCO shall:
(a) Not require the use of a network provider for a family-planning service;
(b) In accordance with 42 C.F.R. 431.51(b), reimburse for a family-planning service provided within or outside of the MCO’s provider network;
(c) Cover an emergency service:
1. In accordance with 42 U.S.C. 1396a-2(b)(2)(A)(i); (ii), (iii), and (iv); (b) Provided within or outside of the MCO’s provider network; or
3. Out of state in accordance with 42 C.F.R. 431.52;
(d) Comply with 42 U.S.C. 1396a-2(b)(2)(A)(ii); and
(e) Be responsible for the provision and costs of a covered service as described in this section beginning on or after the beginning date of enrollment of a recipient with an MCO as established in Section 2 of this administrative regulation.
6. If an enrollee is receiving a medically necessary covered service the day before enrollment with an MCO, the MCO shall be responsible for the costs of continuation of the medically necessary covered service without prior approval and without regard to whether services are provided within or outside the MCO’s network until the MCO can reasonably transfer the enrollee to a network provider.
(b) An MCO shall comply with paragraph (a) of this subsection without impeding service delivery or jeopardizing the enrollee’s health.

Section 30. Enrollees with Special Health Care Needs. (1) In accordance with 42 C.F.R. 438.208:
(a) The following shall be considered an individual with a special health care need:
1. A child in or receiving foster care or adoption assistance; or
2. A homeless individual;
3. An individual with a chronic physical or behavioral illness;
4. A blind or disabled child;
5. An individual who is eligible for SSI benefits; or
6. An adult who is a ward of the Commonwealth in accordance with 910 KAR Chapter 2.
(b) An MCO shall:
1. Have a process to target enrollees for the purpose of screening and identifying those with special health care needs; and
2. Assess each enrollee identified by the department as having a special health care need to determine if the enrollee needs case management or regular care monitoring; and
3. Include the use of appropriate health care professionals to perform an assessment; and
4. Have a treatment plan for an enrollee with a special health care need who has been determined, through an assessment, to need a course of treatment or regular care monitoring.
(2) A treatment plan referenced in subsection (1)(b)(4) of this section shall be developed:
(a) With participation from the enrollee or the enrollee’s legal guardian as referenced in Section 43 of this administrative regulation; and
(b) By the enrollee’s primary care provider, if the enrollee has a primary care provider.
(3) An MCO shall:
(a)1. Develop materials specific to the needs of an enrollee with a special health care need; and
2. Provide the materials referenced in subparagraph 1. of this paragraph to the enrollee, caregiver, parent, or legal guardian;
(b) Have a mechanism to allow an enrollee identified as having a special health care need to directly access a specialist, if appropriate, for the enrollee’s condition and identified need; and
(c) Be responsible for the ongoing care coordination for an enrollee with a special health care need.
(4) The information referenced in subsection (3)(a) of this section shall include health educational material to assist the enrollee with a special health care need or the enrollee’s caregiver, parent, or legal guardian in understanding the enrollee’s special need.
(5)(a) An enrollee who is a child in foster care or receiving adoption assistance shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DCBS prior to being enrolled with the MCO.
(b) The service plan referenced in paragraph (a) of this subsection shall be used by DCBS and the MCO to determine the enrollee’s medical needs and identify the need for case management.
(c) The MCO shall be available to meet with DCBS at least once a month to discuss the health care needs of the child as identified in the service plan.
(d) If a service plan identifies the need for case management or DCBS requests case management for an enrollee, the foster parent of the child or DCBS shall work with the MCO to develop a case management plan of care.
(e) The MCO shall consult with DCBS prior to developing or modifying a case management plan of care.
(6)(a) An enrollee who is a ward of the Commonwealth shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DAIL prior to being enrolled with the MCO.
(b) If the service plan referenced in paragraph (a) of this subsection identifies the need for case management, the MCO shall work with DAIL or the enrollee to develop a case management plan of care.

Section 31. Second Opinion. An enrollee shall have the right to a second opinion within the MCO’s provider network for a surgical procedure or diagnosis and treatment of a complex or chronic condition.

Section 32. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. (1) An MCO shall provide an enrollee under the age of twenty-one (21) years with EPSDT services in compliance with:
(a) 907 KAR 11:034;
(b) 42 U.S.C. 1396d(r); and
(c) The Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule.
(2) A provider of an EPSDT service shall meet the requirements established in 907 KAR 11:034.

Section 33. Emergency Care, Urgent Care, and Poststabilization Care. (1) An MCO shall provide to an enrollee:
(a) Emergency care twenty-four (24) hours a day, seven (7) days a week; and
(b) Urgent care within forty-eight (48) hours.
(2) Poststabilization services shall be provided and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(a).

Section 34. Maternity Care. An MCO shall:
(1) Have procedures to assure:
(a) Prompt initiation of prenatal care or (b) Continuation of prenatal care without interruption for a
woman who is pregnant at the time of enrollment;
2. Provide maternity care that includes:
   a. Prenatal;
   b. Delivery;
   c. Postpartum care; and
   d. Care for a condition that complicates a pregnancy; and
3. Perform all the newborn screenings referenced in 902 KAR 4:030.

Section 35. Pediatric Interface. (1) An MCO shall:
   a. Have procedures to coordinate care for a child receiving a
      school-based health service or an early intervention service; and
   b. Monitor the continuity and coordination of care for the child
      receiving a service referenced in paragraph (a) of this subsection
      as part of its quality assessment and performance improvement
      (QAPI) program established in Section 48 of this administrative
      regulation.
   (2) Except when a child’s course of treatment is interrupted by a
      school break, after-school hours, or summer break, an MCO
      shall not be responsible for a service referenced in subsection
      (1)(a) of this section.
3. A school-based health service provided by a school district
   shall not be covered by an MCO.
   (4) A school-based health service provided by a local health
      department shall be covered by an MCO.

Section 36. Pediatric Sexual Abuse Examination. (1) An MCO
shall enroll at least one (1) provider in its network who has the
capacity to perform a forensic pediatric sexual abuse examination.
(2) A forensic pediatric sexual abuse examination shall be
carried out for an enrollee at the request of the DCBS.

Section 37. Lock-in Program. (1) An MCO shall have a pro-
gram to control utilization of:
   a. Drugs and other pharmacy benefits; and
   b. Non-emergency care provided in an emergency setting.
   (2) The program referenced in subsection (1) of this section
shall be:
   a. Approved by the department; and
   b. In accordance with 907 KAR 1:577.

Section 38. Pharmacy Benefit Program. (1) An MCO shall:
   a. Have a pharmacy benefit program that shall have:
      1. A point-of-sale claims processing service;
      2. Prospective drug utilization review;
      3. An accounts receivable process;
      4. Retrospective utilization review services;
      5. Formulary and non-formulary drugs;
      6. A prior authorization process for drugs;
      7. Pharmacy provider relations;
      8. A toll-free call center that shall respond to a pharmacy or a
         physician prescriber twenty-four (24) hours a day, seven (7)
         days a week; and
      9. A seamless interface with the department’s management
         information system;
   b. Maintain a preferred drug list (PDL);
   c. Provide the following to an enrollee or a provider:
      1. PDL information; and
      2. Pharmacy cost sharing information; and
   d. Have a Pharmacy and Therapeutics Committee (P&T
      Committee), which shall:
      1. Meet periodically throughout the calendar year as neces-
         sary; and
      2. Make recommendations to the MCO for changes to the drug
         formulary.
   (2)(a) The department shall comply with the drug rebate collect-
      ion requirement established in 42 U.S.C. 1396(m)(2)(A)(xii).
   (b) An MCO shall:
      1. Cooperate with the department in complying with 42 U.S.C.
         1396b(m)(2)(A)(xiii); and
      2. Assist the department in resolving a drug rebate dispute with
         a manufacturer; and
      3. Be responsible for drug rebate administration in a non-
         pharmacy setting.
3. An MCO’s P&T committee shall meet and make recom-
   mendations to the MCO for changes to the drug formulary.
   (4) If a prescription for an enrollee is for a non-preferred drug
   and the pharmacist cannot reach the enrollee’s primary care pro-
   vider or the MCO for approval and the pharmacist determines it
   necessary to provide the prescribed drug, the pharmacist shall:
   a. Provide a seventy-two (72) hour supply of the prescribed
      drug;
   b. Provide less than a seventy-two (72) hour supply of the
      prescribed drug, if the request is for less than a seventy-two (72)
      hour supply.
   (5) Cost-sharing imposed by an MCO shall not exceed the cost-
      sharing limits established in 907 KAR 1:604.

Section 39. MCO Interface with the Department Regarding
Behavioral Health. An MCO shall:
   (1) Meet with the department monthly to discuss:
      a. Serious mental illness and serious emotional disturbance
         operating definitions;
      b. Priority populations;
      c. Targeted care management and peer support provider
         certification training and processes;
      d. IMPACT Plus program operations;
      e. Satisfaction survey requirements;
      f. Priority training topics;
      g. Behavioral health services hotline; or
      h. Behavioral health crisis services;
   (2) Coordinate:
      a. An IMPACT Plus covered service provided to an enrollee
         in accordance with 907 KAR 3:030;
      b. With the department:
         1. An enrollee education process for:
            a. Individuals with a serious mental illness; and
            b. Children or youth with a serious emotional disturbance;
         2. On establishing a collaborative agreement with:
            a. State-operated or stated-contracted psychiatric hospital;
            b. Facility that provides a service to an individual with a
               co-
               occurring behavioral health and developmental and intel-
               lectual disabilities; and
      c. With the department and community mental health centers
      a process for integrating a behavioral health service hotline; and
      d. Provide the department with proposed materials and proto-
         cols for the enrollee education referenced in subsection (2)(b) of
         this section.

Section 40. Behavioral Health Services. (1) An MCO shall:
   a. Provide a medically necessary behavioral health service to an
      enrollee in accordance with the access standards established in
      Section 15 of this administrative regulation;
   b. Use the DSM-IV multi-axial classification system to assess
      an enrollee for a behavioral service;
   c. Have an emergency or crisis behavioral health toll-free
      hotline staffed by trained personnel twenty-four (24) hours a day,
      seven (7) days a week;
   d. Not operate one (1) hotline to handle both an emergency or
      crisis call and a routine enrollee call; and
   e. Not impose a maximum call duration limit.
   (2) Staff of a hotline referenced in subsection (1)(c) of this
      section shall:
      a. Communicate in a culturally competent and linguistically
         accessible manner to an enrollee; and
      b. Include or have access to a qualified behavioral health pro-
         fessional to assess and triage a behavioral health emergency.
   (3) A face-to-face emergency service shall be available:
      a. Twenty-four (24) hours a day; and
      b. Seven (7) days a week.

Section 41. Coordination Between a Behavioral Health Provid-
er and a Primary Care Provider. (1) An MCO shall:
   a. Require a PCP to have a screening and evaluation proce-
      dure for the detection and treatment of, or referral for, a known or
      suspected behavioral health problem or disorder;
   b. Provide training to a PCP in its network on:
      1. Screening and evaluating a behavioral health disorder;
2. The MCO’s referral process for a behavioral health service; and
3. Coordination requirements for a behavioral health service; and
4. Quality of care standards;
(c) Have policies and procedures that shall be approved by the department regarding clinical coordination between a behavioral health service provider and a PCP;
(d) Establish guidelines and procedures to ensure accessibility, availability, referral, and triage to physical and behavioral health care;
(e) Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;
(f) Identify a method to evaluate continuity and coordination of care; and
(g) Include the monitoring and evaluation of the MCO’s compliance with the requirements established in paragraphs (a) to (f) of this subsection in the MCO’s quality improvement plan.

Section 42. Court-Ordered Psychiatric Services. (1) An MCO shall:
(a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-one (21) and over the age of sixty-five (65) who has been ordered to receive the service by a court of competent jurisdiction under the provisions of KRS Chapters 202A and 645; and
(b) Refer an enrollee with a known or suspected and untreated physical health problem or disorder to their PCP for examination and treatment; and
(c) Coordinate with a provider of a behavioral health service the treatment objectives and projected length of stay for an enrollee committed by a court of law to a state psychiatric hospital; and
(d) Enter into a collaborative agreement with the state-operated or state-contracted psychiatric hospital assigned to the enrollee’s region in accordance with 908 KAR 3:040 and in accordance with the Olmstead decision.
(2) An MCO shall present a modification or termination of a service referenced in subsection (1)(b) of this section to the court with jurisdiction over the matter for determination.
3. The initial decision was not in writing; and
4. Be evaluated annually by the:
   (a) MCO, including an evaluation of clinical and service outcomes; and
   (b) Department;
(b) Adopt nationally recognized standards of care and written criteria that shall be:
1. Based upon sound clinical evidence, if available, for making utilization decisions; and
2. Approved by the department;
(c) Include physicians and other health care professionals in the MCO network in reviewing and adopting medical necessity criteria;
(d) Have:
1. A process to review, evaluate, and ensure the consistency with which physicians and other health care professionals involved in UM apply review criteria for authorization decisions;
2. A medical director who:
   a. Is licensed to practice medicine or osteopathy in Kentucky;
   b. Is responsible for treatment policies, protocols, and decisions; and
   c. Supervises the UM program; and
3. Written policies and procedures that explain how prior authorization data will be incorporated into the MCO’s Quality Improvement Plan;
   (e) Submit a request for a change in review criteria for authorization decisions to the department for approval prior to implementation;
   (f) Administer or use a CAHPS survey to evaluate and report enrollee and provider satisfaction with the quality of and access to care and services in accordance with Section 55 of this administrative regulation;
   (g) Provide written confirmation of an approval of a request for a service within two (2) business days of providing notification of a decision if:
   1. The initial decision was not in writing; and
   2. Requested by an enrollee or provider;
   (h) If the MCO uses a subcontractor to perform UM, require the subcontractor to have:

Section 44. Utilization Management or UM. (1) An MCO shall:
(a) Have a utilization management program that shall:
1. Meet the requirements established in 42 C.F.R. Parts 422, 428, and 456, and the private review agent requirements of KRS 304.17A, as applicable;
2. Identify, define, and specify the amount, duration, and scope of each service that the MCO is required to offer;
3. Review, monitor, and evaluate the appropriateness and medical necessity of care and services;
4. Identify and describe the UM mechanisms used to:
   a. Detect the under or over utilization of services; and
   b. Act after identifying under utilization or over utilization of services;
5. Have a written UM program description in accordance with subsection (2) of this section; and
6. Be evaluated annually by the:
   a. MCO, including an evaluation of clinical and service outcomes; and
   b. Department; and
(b) A case manager and a behavioral health service provider shall:
1. Participate in a quarterly continuity of care meeting with a state-operated or state-contracted psychiatric hospital;
2. Assign a case manager prior to or on the date of discharge of an enrollee from a state-operated or state-contracted psychiatric hospital; and
3. Provide case management services to an enrollee with a severe mental illness and co-occurring developmental disability who is discharged from:
   a. State-operated or state-contracted psychiatric hospital; or
   b. State-operated nursing facility for individuals with severe mental illness;
(b) A case manager and a behavioral health service provider shall participate in discharge planning to ensure compliance with the Olmstead decision.

Section 43. Legal Guardians. (1) A parent, custodial parent, person exercising custodial control or supervision, or an agency with a legal responsibility for a child by virtue of a voluntary commitment or of an emergency or temporary custody order shall be authorized to act on behalf of an enrollee who is under the age of eighteen (18) years, a potential enrollee, or a former enrollee for the purpose of:
(a) Selecting a primary care provider;
(b) Filing a grievance or appeal; or
(c) Taking an action on behalf of the child regarding an interaction with an MCO.
(2)(a) A legal guardian who has been appointed pursuant to KRS 387.500 to 387.800 shall be allowed to act on behalf of an enrollee who is a ward of the commonwealth.
(b) A person authorized to make a health care decision pursuant to KRS 311.621 to 311.643 shall be allowed to act on behalf of an enrollee, potential enrollee, or former enrollee.
(c) An enrollee shall have the right to:
1. Represent the enrollee; or
2. Use legal counsel, a relative, a friend, or other spokesperson.

Section 44. Utilization Management or UM. (1) An MCO shall:
(a) Have a utilization management program that shall:
1. Meet the requirements established in 42 C.F.R. Parts 422, 428, and 456, and the private review agent requirements of KRS 304.17A, as applicable;
2. Identify, define, and specify the amount, duration, and scope of each service that the MCO is required to offer;
3. Review, monitor, and evaluate the appropriateness and medical necessity of care and services;
4. Identify and describe the UM mechanisms used to:
   a. Detect the under or over utilization of services; and
   b. Act after identifying under utilization or over utilization of services;
5. Have a written UM program description in accordance with subsection (2) of this section; and
6. Be evaluated annually by the:

Section 45. Legal Guardians. (1) A parent, custodial parent, person exercising custodial control or supervision, or an agency with a legal responsibility for a child by virtue of a voluntary commitment or of an emergency or temporary custody order shall be authorized to act on behalf of an enrollee who is under the age of eighteen (18) years, a potential enrollee, or a former enrollee for the purpose of:
(a) Selecting a primary care provider;
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(c) Taking an action on behalf of the child regarding an interaction with an MCO.
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(a) Selecting a primary care provider;
(b) Filing a grievance or appeal; or
(c) Taking an action on behalf of the child regarding an interaction with an MCO.
(2)(a) A legal guardian who has been appointed pursuant to
Section 46. Health Risk Assessment. An MCO shall:
(1) After the initial implementation of the MCO program, conduct an initial health risk assessment of each enrollee within ninety (90) days of enrolling the individual if the individual has not been enrolled with the MCO in a prior twelve (12) month period;
(2) Use health care professionals in the health risk assessment process;
(3) Screen an enrollee who it believes to be pregnant within thirty (30) days of enrollment; and
(4) By the:
(a) The date of action for the following:
(i) The death of a member;
(ii) A signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services in which the enrollee understands this will be the result of supplying the information;
(iii) The enrollee's address is unknown and mail directed to the enrollee has no forwarding address;
(iv) The enrollee's address is known but the enrollee does not reside in the county, or
(v) The enrollee's admission to an institution results in the enrollee's ineligibility for more services;
(vi) The enrollee's physician prescribes a change in the level of medical care;
(vii) An adverse decision has been made regarding the preauthorization of an enrollee's medical care; or
(viii) The safety or health of individuals in a facility would be endangered, if the enrollee's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the enrollee's urgent medical needs, or an enrollee has not resided in the nursing facility for thirty (30) days;
(c) On the date of action, if the action is a denial of payment;
(d) As expeditiously as the enrollee's health condition requires and within two (2) business days following receipt of a request; and
(e) When the MCO carries out its authorization decision, as expeditiously as the enrollee's health condition requires and no later than the date the extension as identified in subsection (3) of this section expires;
(f) If a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the enrollee's life or health, or ability to attain, maintain or regain maximum function, as expeditiously as the enrollee's health condition requires and no later than two (2) business days after receipt of the request for service; and
(g) For an authorization decision not made within the timeframe identified in subsection (2) of this section, on the date the timeframe expires as shall constitute a denial.

Section 45. Service Authorization and Notice. (1) For the processing of a request for initial or continuing authorization of a service, an MCO shall identify what constitutes medical necessity and establish a written policy and procedure, which includes a timeframe for:
(a) Making an authorization decision; and
(b) If the service is denied or authorized in an amount, duration, or scope which is less than requested, providing a notice to the enrollee and provider acting on behalf of and with the consent of an enrollee.
(2) For an authorization of a service, an MCO shall make a decision:
(a) As expeditiously as the enrollee's health condition requires; and
(b) Within two (2) business days following receipt of a request for service.
The timeframe for making an authorization decision referenced in subsection (2) of this section may be extended:
(a) By the:
1. Enrollee, or the provider acting on behalf of and with consent of an enrollee, if the enrollee requests an extension; or
2. MCO, if the MCO:
   a. Justifies to the department, upon request, a need for additional information and how the extension is in the enrollee's interest;
   b. Gives the enrollee written notice of the extension, including the reason for extending the authorization decision timeframe and the right of the enrollee to file a grievance if the enrollee disagrees with that decision; and
   c. Makes and carries out the authorization decision as expeditiously as the enrollee's health condition requires and no later than the date the extension expires; and
(b) Up to fourteen (14) additional calendar days.
(3) If an MCO denies a service authorization or authorizes a service in an amount, duration, or scope which is less than requested, the MCO shall provide a notice:
(a) To the:
1. Enrollee, in writing, as expeditiously as the enrollee's condition requires and within two (2) business days of receipt of the request for service; and
2. Requesting provider, if applicable;
(b) Which shall:
1. Meet the language and formatting requirements established in 42 C.F.R. 438.404;
2. Include the:
   a. Action the MCO or its subcontractor, if applicable, has taken or intends to take;
   b. Reason for the action;
   c. Right of the enrollee or provider who is acting on behalf of the enrollee to file an MCO appeal;
   d. Right of the enrollee to request a state fair hearing;
   e. Procedure for filing an appeal and requesting a state fair hearing;
   f. Statement of the enrollee's health condition as specified under this section;
   g. Right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services; and
3. Be provided:
   a. At least ten (10) days before the date of action if the action is: a termination, suspension, or reduction of a covered service authorized by the department, department designee, or enrollee's MCO, except the department may shorten the period of advance notice to five (5) days before the date of action because of probable fraud by the enrollee;
   b. By the date of action for the following:
      (i) The death of a member;
      (ii) A signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services in which the enrollee understands this will be the result of supplying the information;
   (ii) The enrollee's address is unknown and mail directed to the enrollee has no forwarding address;
   (iii) The enrollee's address is known but the enrollee does not reside in the county, or
   (iv) The enrollee's admission to an institution results in the enrollee's ineligibility for more services;
   (vi) The enrollee's physician prescribes a change in the level of medical care;
   (vii) An adverse decision has been made regarding the preauthorization of an enrollee's medical care; or
   (viii) The safety or health of individuals in a facility would be endangered, if the enrollee's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the enrollee's urgent medical needs, or an enrollee has not resided in the nursing facility for thirty (30) days;
   c. On the date of action, if the action is a denial of payment;
   d. As expeditiously as the enrollee's health condition requires and within two (2) business days following receipt of a request; and
   e. When the MCO carries out its authorization decision, as expeditiously as the enrollee's health condition requires and no later than the date the extension as identified in subsection (3) of this section expires;
   f. If a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the enrollee's life or health, or ability to attain, maintain or regain maximum function, as expeditiously as the enrollee's health condition requires and no later than two (2) business days after receipt of the request for service; and
   g. For an authorization decision not made within the timeframe identified in subsection (2) of this section, on the date the timeframe expires as shall constitute a denial.

Section 47. Medical Necessity Review Process. (1) An MCO shall:
(a) Designate an individual as the initial reviewer; and
(b) Designate an individual as the initial reviewer.
(2) The timeframe for making an authorization decision referenced in subsection (2) of this section may be extended:
(a) By the:
1. Enrollee, in writing, as expeditiously as the enrollee's health condition requires and no later than the date the extension expires; and
(b) Up to fourteen (14) additional calendar days.
(3) If an MCO denies a service authorization or authorizes a service in an amount, duration, or scope which is less than requested, the MCO shall provide a notice:
(a) To the:
1. Enrollee, in writing, as expeditiously as the enrollee's condition requires and within two (2) business days of receipt of the request for service; and
2. Requesting provider, if applicable;
(b) Which shall:
1. Meet the language and formatting requirements established in 42 C.F.R. 438.404;
2. Include the:
   a. Action the MCO or its subcontractor, if applicable, has taken or intends to take;
   b. Reason for the action;
   c. Right of the enrollee or provider who is acting on behalf of the enrollee to file an MCO appeal;
   d. Right of the enrollee to request a state fair hearing;
   e. Procedure for filing an appeal and requesting a state fair hearing;
   f. Statement of the enrollee's medical condition or disease that is in need of authorization;
   g. Right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services; and
3. Be provided:
   a. At least ten (10) days before the date of action if the action is: a termination, suspension, or reduction of a covered service authorized by the department, department designee, or enrollee's MCO, except the department may shorten the period of advance notice to five (5) days before the date of action because of probable fraud by the enrollee;
   b. By the date of action for the following:
      (i) The death of a member;
      (ii) A signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services in which the enrollee understands this will be the result of supplying the information;
   (ii) The enrollee's address is unknown and mail directed to the enrollee has no forwarding address;
   (iii) The enrollee's address is known but the enrollee does not reside in the county, or
   (iv) The enrollee's admission to an institution results in the enrollee's ineligibility for more services;
   (vi) The enrollee's physician prescribes a change in the level of medical care;
   (vii) An adverse decision has been made regarding the preauthorization of an enrollee's medical care; or
   (viii) The safety or health of individuals in a facility would be endangered, if the enrollee's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the enrollee's urgent medical needs, or an enrollee has not resided in the nursing facility for thirty (30) days;
   c. On the date of action, if the action is a denial of payment;
   d. As expeditiously as the enrollee's health condition requires and within two (2) business days following receipt of a request; and
   e. When the MCO carries out its authorization decision, as expeditiously as the enrollee's health condition requires and no later than the date the extension as identified in subsection (3) of this section expires;
   f. If a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the enrollee's life or health, or ability to attain, maintain or regain maximum function, as expeditiously as the enrollee's health condition requires and no later than two (2) business days after receipt of the request for service; and
   g. For an authorization decision not made within the timeframe identified in subsection (2) of this section, on the date the timeframe expires as shall constitute a denial.

Section 48. Processing of a Request for Initial or Continuing Authorization of a Service. An MCO shall:
(1) After the initial implementation of the MCO program, conduct an initial health risk assessment of each enrollee within ninety (90) days of enrolling the individual if the individual has not been enrolled with the MCO in a prior twelve (12) month period;
Section 47. Care Coordination and Management. An MCO shall:

1. Have a care coordinator and a case manager who shall:
   a. Arrange, assure delivery of, monitor, and evaluate care, treatment, and services for an enrollee; and
   b. Not duplicate or supplant services provided by a targeted case manager to:
      1. Adults with a chronic mental illness pursuant to 907 KAR 1:515; or
      2. Children with a severe emotional disability pursuant to 907 KAR 1:525;

2. Have guidelines for care coordination that shall be approved by the department prior to implementation;

3. Develop a plan of care for an enrollee in accordance with 42 C.F.R. 438.208;

4. Have policies and procedures to ensure access to care coordination for a DCBS client or a DAIL client;

5. Provide information on and coordinate services with the Women, Infants and Children program; and

6. Provide information to an enrollee and a provider regarding:
   a. An available care management service; and
   b. How to obtain a care management service.

Section 48. Quality Assessment and Performance Improvement (QAPI) Program. An MCO shall:

1. Outlines the scope of activities;

2. Consider the needs of enrollees; and

3. Include consultation with network providers.

Section 49. Quality Assessment and Performance Improvement Plan. (1) An MCO shall:

(a) Have a written QAPI work plan that:
   1. Outlines the scope of activities;
   2. Is submitted quarterly to the department; and
   3. Sets goals, objectives, and timelines for the QAPI program;
   (b) Set new goals and objectives:
      1. At least annually; and
      2. Based on a finding:
         a. A quality improvement activity or study;
         b. A survey result;
         c. A grievance or appeal;
         d. A performance measure; or
         e. The External Quality Review Organization;
   (c) Be accountable to the department for the quality of care provided to an enrollee;
   (d) Obtain approval from the department for its QAPI program and annual QAPI work plan;
   (e) Have an accountable entity within the MCO:
      1. To provide direct oversight of its QAPI program; and
      2. To review reports from the quality improvement committee referenced in paragraph (h) of this subsection;
   (f) Review its QAPI program annually;
   (g) Modify its QAPI program to accommodate a review finding or concern from the department or a quality improvement committee referred to in paragraph (b) of this subsection;
   (h) Have a quality improvement committee that shall:
      1. Be responsible for the QAPI program;
      2. Be interdisciplinary;
      3. Include:
         a. Providers and administrative staff; and
         b. Health professionals with knowledge of and experience with individuals with special health care needs;
      4. Meet on a regular basis;
      5. Document activities of the committee;
      6. Make committee minutes and a committee report available to the department upon request; and
      7. Submit a report to the accountable entity referenced in paragraph (a) of this subsection that shall include:
         a. A description of the QAPI activities;
         b. Progress on objectives; and
         c. Improvements made;
   (i) Require a provider to participate in QAPI activities in the provider agreement or subcontract; and
   (j) Provide feedback to a provider or a subcontractor regarding integration or operation of a corrective action necessary in a QAPI activity if a corrective action is necessary.

2. Have a QAPI activity that shall:
   (a) Conform to the requirements of 42 C.F.R. 438 Subpart D, 438.200 to 438.242;
   (b) Assess, monitor, evaluate, and improve the quality of care provided to an enrollee;
   (c) Provide for the evaluation of:
      1. Access to care;
      2. Continuity of care;
      3. Health care outcomes; and
      4. Services provided or arranged for by the MCO;
   (d) Demonstrate the linkage of Quality Improvement (QI) activities to findings from a quality evaluation; and
   (e) Be developed in collaboration with input from enrollees;
   (f) Submit annually to the department a description of its QAPI program; and
   (g) Conduct and submit to the department an annual review of the program;

3. Maintain documentation:
   (a) Of enrollee input;
   (b) Of the MCO’s response to the enrollee input;
   (c) Of a performance improvement activity; and
   (d) Of feedback to an enrollee;

4. Have or obtain within four (4) years of initial implementation National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line;

5. If the MCO has obtained NCQA accreditation:
   (a) Submit to the department a copy of its current certificate of accreditation with a copy of the complete accreditation survey report; and
   (b) Maintain the accreditation;

6. Integrate behavioral health service indicators into its QAPI program;

7. Include a systematic, on-going process for monitoring, evaluating, and improving the quality and appropriateness of a behavioral health service provided to an enrollee;

8. Collect data, monitor, and evaluate for evidence of improvement to a physical health outcome resulting from integration of behavioral health into an enrollee’s care; and

9. Annually review and evaluate the effectiveness of the QAPI program.

Section 50. QAPI Monitoring and Evaluation. (1) Through its QAPI program, an MCO shall:

(a) Monitor and evaluate the quality of health care provided to an enrollee;

(b) Study and prioritize health care needs for performance measurement, performance improvement, and development of practice guidelines;

(c) Use a standardized quality indicator:
   1. To assess improvement, assure achievement of at least a minimum performance level, monitor adherence to a guideline, and identify a pattern of over and under utilization of a service; and
   2. Which shall be:
      a. Supported by a valid data collection and analysis method; and
      b. Used to improve clinical care and services;

(d) Measure a provider performance against a practice guideline and a standard adopted by the quality improvement committee;

(e) Use a multidisciplinary team to analyze and address data and systems issues; and

(f) Have practice guidelines that shall:
   1. Be:
      a. Disseminated to a provider, or upon request, to an enrollee;
      b. Based on valid and reliable medical evidence or consensus of health professionals;
      c. Reviewed and updated; and
      d. Used by the MCO in making a decision regarding utilization management, a covered service, or enrollee education;
   2. Consider the needs of enrollees; and
   3. Include consultation with network providers.
Section 51. Quality and Member Access Committee. (1) An MCO shall:
(a) Have a Quality and Member Access Committee (OMAC) composed of:
   (1) Enrollees who shall be representative of the enrollee population;
   (2) Individuals from consumer-advocacy groups or the community who shall represent the interests of enrollees in the MCO; and
(b) Submit to the department annually a list of enrollee representatives participating in the OMAC.
(2) A OMAC shall be responsible for reviewing:
(a) Quality and access standards;
(b) The grievance and appeals process;
(c) Policy modifications needed based on reviewing aggregate grievance and appeals data;
(d) The member handbook;
(e) Enrollee education materials;
(f) Community outreach activities; and
(g) MCO and department policies that affect enrollees.
(3) The OMAC shall provide the results of its reviews to the MCO.

Section 52. External Quality Review. (1) In accordance with 42 U.S.C. 1396a(a)(30), the department shall have an independent external quality review organization (EORO) annually review the quality of services provided by an MCO.
(2) An MCO shall:
(a) Provide information to the EORO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Parts 433 and 438; and
(b) Cooperate and participate in external quality review activities in accordance with the protocol established in 42 C.F.R. 438 Subpart E. 438.310 to 438.370.
(3) The department shall have the option of using information from a Medicare or private accreditation review of an MCO in accordance with 42 C.F.R. 438.360.
(4) If an adverse finding or deficiency is identified by an EORO conducting an external quality review, an MCO shall correct the finding or deficiency.

Section 53. Health Care Outcomes. An MCO shall:
(1) Comply with the requirements established in 42 C.F.R. 438.240 relating to quality assessment and performance improvement activities specific to the MCO if:
(a) There is a finding of noncompliance described in 42 C.F.R. 438.240(a)(3) for which the MCO is subject to an external quality review organization conducted by NCQA.
(b) The MCO has not corrected the adverse finding or deficiency.

Section 54. Performance Improvement Projects (PIPs). (1) An MCO shall:
(a) Implement PIPs to address aspects of clinical care and non-clinical services;
(b) Collaborate with local health departments, behavioral health agencies, and other community-based health or social service agencies to achieve improvements in priority areas;
(c) Initiate a minimum of two (2) PIPs each year with at least one (1) PIP relating to physical health and at least one (1) PIP relating to behavioral health;
(d) Report on a PIP using standardized indicators;
(e) Specify a minimum performance level for a PIP; and
(f) Include the following for a PIP:
   1. The topic and its importance to enrolled members;
   2. Methodology for topic selection;
   3. Goals of the PIP;
   4. Data sources and collection methods;
   5. An intervention; and
   6. Results and interpretations.
(2) A clinical PIP shall address preventive and chronic healthcare needs of enrollees including:
(a) The enrollee population;
(b) A subpopulation of the enrollee population; and
(c) Specific clinical needs of enrollees with conditions and illnesses that have a higher prevalence in the enrolled population.
(3) A non-clinical PIP shall address improving the quality, availability, and accessibility of services provided by an MCO to enrollees and providers.
(4) The department may require an MCO to implement a PIP specific to the MCO if:
(a) A finding from an EORO review referenced in Section 52 of this administrative regulation or an audit indicates a need for a PIP, or
(b) Directed by CMS.
(5) The department shall be authorized to require an MCO to assist in a statewide PIP which shall be limited to providing the department with data from the MCO’s service area.

Section 55. Enrollee and Provider Surveys. (1) An MCO shall:
(a) Conduct an annual survey of enrollee and provider satisfaction with the quality and accessibility to a service provided by an MCO;
(b) Satisfy a member satisfaction survey requirement by participating in the Agency for Health Research and Quality’s current Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) for Medicaid Adults and Children, which shall be administered by an NCQA certified survey vendor;
(c) Provide a copy of the current CAHPS survey referenced in paragraph (b) of this subsection to the department;
(d) Annually assess the need for conducting other surveys to support quality and performance improvement initiatives;
(e) Submit to the department for approval the survey tool used to conduct the survey referenced in paragraph (a) of this subsection; and
(f) Provide to the department:
   1. A copy of the results of the enrollee and provider surveys referenced in paragraph (a) of this subsection;
   2. A description of a methodology to be used to conduct surveys;
   3. The number and percentage of enrollees and providers surveyed;
   4. Enrollee and provider survey response rates;
   5. Enrollee and provider survey findings; and
   6. Interventions conducted or planned by the MCO related to activities in this section.
(2) The department shall:
(a) Approve enrollee and provider survey instruments prior to implementation; and
(b) Approve or disapprove an MCO’s provider survey tool with fifteen (15) days of receipt of the survey tool.
(3) If an MCO conducts a survey that targets a subpopulation’s perspective or experience with access, treatment, or services, the MCO shall comply with the requirements established in subsection (1)(e) and (f) of this section.
Section 56. Prompt Payment of Claims. (1) In accordance with 42 U.S.C. 1396a(a)(37), an MCO shall have prepayment and post-payment claims review procedures that ensure the proper and efficient payment of claims and management of the program.

(2) An MCO shall:
   (a) Comply with the prompt payment provisions established in 42 C.F.R. 447.45; and
   (b) Authorize a service in an amount, duration, or scope that is less than requested.

(3) The payment provisions in this section shall apply to a payment to:
   (a) A provider within the MCO network; and
   (b) An out-of-network provider.

Section 57. Payments to an MCO. (1) The department shall provide an MCO a per-enrollee, per-month capitation payment whether or not the enrollee receives a service during the period covered by the payment except for an enrollee whose eligibility is determined due to being unemployed in accordance with 45 C.F.R. 233.100.

(2) The monthly capitation payment for an enrollee whose eligibility is determined due to being unemployed shall be prorated from the date of eligibility.

(3) A capitation rate referenced in subsection (1) of this section shall:
   (a) Meet the requirements of 42 C.F.R. 438.6(c); and
   (b) Be approved by the Centers for Medicare and Medicaid Services.

(4) The department shall apply a risk adjustment to a capitation rate in an amount that shall be budget neutral to the department.

(5) The department shall use the latest version of the Chronic Illness and Disability Payment System to determine the risk adjustment referenced in paragraph (a) of this subsection.

Section 58. Recoupment of Payment from an Enrollee for Fraud, Waste, or Abuse. (1) If an enrollee is determined to be ineligible for Medicaid through an administrative hearing or adjudication of fraud by the CHFS OIG, the department shall recoup a capitation payment it has made to an MCO on behalf of the enrollee.

(2) An MCO shall request a refund from the enrollee referenced in subsection (1) of this section of a payment the MCO has made to a provider for the service provided to the enrollee.

(3) If an MCO has been unable to collect a refund referenced in subsection (2) of this section within six (6) months, the Commonwealth shall have the right to recover the refund from the enrollee.

Section 59. MCO Administration. An MCO shall have executive management responsibility for operations and functions of the MCO that shall include:

(1) An executive director who shall:
   (a) Act as a liaison to the department regarding a contract between the MCO and the department;
   (b) Be authorized to represent the MCO regarding an inquiry pertaining to a contract between the MCO and the department;
   (c) Have decision-making authority; and
   (d) Be responsible for following up regarding a contract inquiry or issue.

(2) A medical director who shall be:
   (a) A physician licensed to practice medicine in Kentucky;
   (b) Actively involved in all major clinical programs and quality improvement components of the MCO; and
   (c) Available for after-hours consultation.

(3) A dental director who shall be:
   (a) Licensed by a dental board of licensure in any state;
   (b) Actively involved in all oral health programs of the MCO; and
   (c) Available for after-hours consultation.

(4) A finance officer who shall oversee the MCO's budget and accounting systems and:
   (a) A behavioral health practitioner;

   (b) Actively involved in all of the MCO's programs or initiatives relating to behavioral health and
   (c) Responsible for the coordination of behavioral health services provided by the MCO or any of its behavioral health subcontractors.

(7) A case management coordinator who shall be responsible for coordinating and overseeing case management services and continuity of care for MCO enrollees.

(8) An early and periodic screening, diagnosis, and treatment (EPSDT) coordinator who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for MCO enrollees.

(9) A foster care and subsidized adoption care liaison who shall serve as the MCO's primary liaison for meeting the needs of an enrollee who is:
   (a) A child in foster care; or
   (b) A child receiving state-funded adoption assistance.

(10) A guardianship liaison who shall serve as the MCO's primary liaison for meeting the needs of an enrollee who is a ward of the Commonwealth.

(11) A management information systems director who shall oversee, manage, and maintain the MCO's management information system.

(12) A program integrity coordinator who shall coordinate, manage, and oversee the MCO's program integrity functions.

(13) A pharmacy director who shall coordinate, manage, and oversee the MCO's pharmacy program.

(14) A compliance director who shall be responsible for the MCO's:
   (a) Financial and programmatic accountability, transparency, and integrity; and
   (b) Compliance with:
      1. All applicable federal and state law;
      2. Any administrative regulation promulgated by the department relating to the MCO; and
      3. The requirements established in the contract between the MCO and the department.

(15) A member services director who shall:
   (a) Coordinate communication with MCO enrollees; and
   (b) Respond in a timely manner to an enrollee seeking a resolution of a problem or inquiry.

(16) A provider services director who shall:
   (a) Coordinate communication with MCO providers and subcontractors; and
   (b) Respond in a timely manner to a provider seeking a resolution of a problem or inquiry.

(17) A claims processing director who shall ensure the timely and accurate processing of claims.

Section 60. MCO Reporting Requirements. An MCO shall:

(1) Submit to the department a report as required by MCO Reporting Requirements.

(2) Verify the accuracy of data and information on a report submitted to the department.

(3) Analyze a required report to identify an early pattern of change, trend, or outlier before submitting the report to the department.

(4) Submit the analysis required in subsection (3) of this section with a required report.

Section 61. Health Care Data Submission and Penalties. (1)(a) An MCO shall submit an original encounter record and denial encounter record, if any, to the department weekly.

(b) An original encounter record or a denial encounter record
shall be considered late if not received by the department within four (4) calendar days from the weekly due date.

(c) Beginning on the fifth calendar day late, the department shall withhold $500 per day for each day late from an MCO’s total capital-payment for the month following non-submission of an original encounter record and denial encounter record.

(2) If an MCO fails to submit health care data derived from processed claims or encounter data in a format or format established in the MCO Reporting Requirements for one (1)-calendar month, the department shall withhold an amount equal to five (5) percent of the MCO’s capital-payment for the month following non-submission.

(b) The department shall retain the amount referenced in paragraph (a) of this subsection until the data is received and accepted by the department, less $500 per day for each day late.

(3)(a) The department shall transmit to an MCO an encounter record with an error for correction by the MCO.

(b) An MCO shall have ten (10) days to submit a corrected encounter record.

(c) If an MCO fails to submit a corrected encounter record within the time frame specified in paragraph (b) of this subsection, the department shall be able to assess and withhold for the month following the non-submission, an amount equal to one-tenth of a percent of the MCO’s total capital-payment per day until the corrected encounter record is received and accepted by the department.

Section 62. Program Integrity. An MCO shall comply with:

(1) 42 C.F.R. 438.608;
(2) 42 U.S.C. 1396a(e)(68); and
(3) The requirements established in the MCO-Program Integrity Requirements.

Section 63. Third Party Liability and Coordination of Benefits. Medicaid shall be the payer of last resort for a service provided to an enrollee.

(2) An MCO shall:

(a) Assign, in writing, the enrollee’s rights to an MCO for a service provided to an enrollee.
(b) Be responsible for determining a legal liability of a third party to pay for a service provided to an enrollee.
(c) Actively seek and identify a third party liability resource to pay for a service provided to an enrollee in accordance with 42 C.F.R. 433.138; and
(d) Assure that Medicaid shall be the payer of last resort for a service provided to an enrollee.

(3) In accordance with 407 KAR 1:011 and KRS 205.624, an enrollee shall:

(a) Assign, in writing, the enrollee’s rights to an MCO for a medical support or payment from a third party for a medical service provided by the MCO; and
(b) Cooperate with an MCO in identifying and providing information to assist the MCO in pursuing a third party that shall be liable to pay for a service provided by the MCO.

(4) If an MCO becomes aware of a third party liability resource after payment for a service provided to an enrollee, the MCO shall seek recovery from the third party resource.

(5) An MCO shall have a process for third party liability and coordination of benefits in accordance with Third Party Liability and Coordination of Benefits.

Section 64. Management Information System. (1) An MCO shall:

(a) Have a management information system that shall:

1. Provide support to the MCO operations; and
2. Except as provided in subsection (2) of this section, include
   a. Member subsystem;
   b. Third-party liability subsystem;
   c. Provider subsystem;
   d. Reference subsystem;
   e. Claim processing subsystem;
   f. Financial subsystem;
   g. Utilization and quality improvement subsystem; and
   h. Surveillance utilization review subsystem; and
   i. Transmit data to the department in accordance with 42 C.F.R. 438.242 and the Management Information System Requirements.

(2) An MCO’s management information system shall not be required to have the subsystems listed in subsection (1)(a)2. of this section if the MCO’s management information system:

(a) Has the capacity to:

1. Capture and provide the required data captured by the subsystems listed in subsection (1)(a)2. of this section; and
2. Provide the data in formats and files that shall be consistent with the subsystems listed in subsection (1)(a)2. of this section; and

(b) Meets the requirements established in paragraph (a) of this subsection in a way which shall be mapped to the subsystem concept established in subsection (1)(a)2. of this section.

(3) If an MCO subcontracts for services, the MCO shall provide guidelines for its subcontractor to the department for approval.

Section 65. Kentucky Health Information Exchange (KHIE). (1) An MCO shall:

(a) Submit to the KHIE:

1. An adjudicated claim within twenty-four (24) hours of the final claim adjudication; and
2. Clinical data as soon as it is available;

(b) Make an attempt to have a PCC in the MCO's network connect to KHIE within:

1. One (1) year of enrollment in the MCO’s network; or
2. A timeframe approved by the department if greater than one (1) year; and

(c) Encourage a provider in its network to establish connectivity with the KHIE.

(2) The department shall:

(a) Administer an electronic health record incentive payment program; and
(b) Inform an MCO of a provider that has received an electronic health record incentive payment.

Section 66. MCO Qualifications and Maintenance of Records. (1) An MCO shall:

(a) Be licensed by the Department of Insurance as a health maintenance organization or an insurer;

(b) Have a governing body;

(c) Have protection against insolvency in accordance with:
1. 806 KAR 3:190; and
2. 42 C.F.R. 438.116;

(d) Maintain all books, records, and information related to MCO providers, recipients, or recipient services, and financial transactions for:

1. A minimum of five (5) years in accordance with 407 KAR 1:672; and

2. Any additional time period as required by federal or state law; and

(e) Submit a request for disclosure of information subject to open records laws, KRS 61.870 to 61.884, received from the public to the department within twenty-four (24) hours.

(2) Information shall not be disclosed by an MCO pursuant to a request it received pursuant to subsection (1)(e) of this section without prior written authorization from the department.

(3) The books, records, and information referenced in subsection (1)(d) of this section shall be available upon request of a reviewer or auditor during routine business hours at the MCO’s place of operations.

(4) MCO staff shall be available upon request of a reviewer or auditor during routine business hours at the MCO’s place of operations.

Section 67. Prohibited Affiliations. The policies or requirements:

(1) Imposed on a managed care entity in 42 U.S.C. 1396u-2(d)(1) shall apply to an MCO; and
(2) Established in 42 C.F.R. 438.610 shall apply to an MCO.

Section 68. Termination of MCO Participation in the Medicaid
Section 69. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) “MCO Reporting Requirements”, July 2011 edition;
(b) “MCO Program Integrity Requirements”, July 2011 edition;
(c) “Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule”, July 2011 edition;
(d) “Third Party Liability and Coordination of Benefits”, July 2011 edition and
(2) This material may be inspected, copied, or obtained subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621. Monday through Friday, 8 a.m. to 4:30 p.m., or from its Web site at http://www.chfs.ky.gov/dms/incorporated.htm. (38 Ky.R. 1249; 1588; 1738; eff. 5-4-12.)907 KAR 17:005

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2013 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email jill.brown@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT
Contact Person: Stuart Owen
(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation currently establishes Kentucky Medicaid program managed care policies [excluding MCO policies for region three (3) of Kentucky.] Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities — including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions — one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than this lone administrative regulation. DMS is doing this to achieve uniformity across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. This administrative regulation; thus, will contain the definitions for Medicaid managed care administrative regulations. The other administrative regulations are new administrative regulations (907 KAR 17:010, 907 KAR 17:015, 907 KAR 17:020, 907 KAR 17:025 and 907 KAR 17:030) which will address subjects previously addressed in this administrative regulation and are all being promulgated concurrently along with this amended administrative regulation.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for chapter 17 of title 907 — which is the chapter that contains Kentucky Medicaid program managed care regulations. The definitions are not being amended from what is currently stated in this administrative regulation. DMS is establishing MCO requirements and policies in multiple administrative regulations rather than in this lone administrative regulation. DMS is doing this in response to urging from the Administrative Regulation Review Subcommittee and staff when this administrative regulation was reviewed by the committee earlier this year.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the definitions for chapter 17 of title 907 — which is the chapter that contains Kentucky Medicaid program managed care regulations.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the definitions for chapter 17 of title 907 — which is the chapter that contains Kentucky Medicaid program managed care regulations.
(e) How the amendment will change this existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This administrative regulation currently establishes Kentucky Medicaid program managed care policies but is being amended to establish the definitions for chapter 17 of title 907 — which is the chapter that contains Kentucky Medicaid program managed care regulations. The Department for Medicaid Services (DMS) is dividing the current regulation into four (4) regulations.
(b) The necessity of the amendment to this administrative regulation: DMS is dividing the administrative regulation into four (4) in response to a request by the Administrative Regulation Review Subcommittee and staff when the regulation previously was reviewed by the Subcommittee.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will assist the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by establishing the definitions for chapter 17 of title 907 — which is the chapter that contains Kentucky Medicaid program managed care regulations.
(b) How the amendment will assist in the effective administration of the authorizing statutes: The amendment will assist in the effective administration of the authorizing statutes by establishing the definitions for chapter 17 of title 907 — which is the chapter that contains Kentucky Medicaid program managed care regulations.
(c) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.
(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.
(5) Provide an estimate of how much it will cost to implement
this administrative regulation:

(a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.

(b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation establishes definitions to be used for regulations contained in chapter 17 of title 907 of the Kentucky Administrative Regulations.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438.

2. State compliance standards. KRS 205.520(3) states, “Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary’s power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care but does not impose additional or stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A managed care method of administering the program is being implemented but stricter requirements are not imposed. A managed care program is not federally mandated for Medicaid programs.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,198,870,633.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2014 are $3,303,448,347.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation. Revenue (+/-): Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Community Based Services
Division of Family Support
(Amendment)

STATUTORY AUTHORITY: KRS 194A.050(1), 205.245, 42 U.S.C. 1382e-g
NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the secretary to promulgate administrative regulations necessary under applicable state laws to protect, develop, and maintain the welfare, personal dignity, integrity, and sufficiency of the citizens of the Commonwealth and to operate the programs and fulfill the responsibilities of the cabinet. 42 U.S.C. 1382 authorizes the cabinet to administer a state funded program of supplementation to all former recipients of the Aid to the Aged, Blind and Disabled Program as of December 13, 1973, and who were disadvantaged by the implementation of the Supplemental Security Income Program. KRS 205.245 establishes the mandatory supplementation program and the supplementation to other needy persons who are aged, blind, or have a disability. In addition, any state that makes supplementary payments on or after June 30, 1977, and does not have a pass-along agreement in effect with the Commissioner of the Social Security Administration, formerly a part of the U.S. Department of Health, Education, and Welfare [Department of Health and Human Services Commissioner in effect] shall be determined by the commissioner to be ineligible for payments under Title XIX of the Social Security Act in accordance with 20 C.F.R. 416.2099. This administrative regulation establishes the provisions of the supplementation program.

Section 1. Definitions. (1) "Adult" is defined by KRS 209.020(4).

(2) "Aid to the Aged, Blind and Disabled Program" means the former state-funded program for an individual who was aged, blind, or had a disability.

(3) "Department" means the Department for Community Based Services or its designee.

(4) "Elder Shelter" means a temporary shelter for a victim of elder abuse.

(5) "Full-time living arrangement" means a residential living status that is seven (7) days a week, not part time.

(6) "Qualified alien" means an alien who, at the time the person applies for, receives, or attempts to receive state supplementation, meets the U.S. citizenship requirements of 907 KAR 1813.
Section 2. Mandatory State Supplementation. (1) A recipient for mandatory state supplementation shall include a former Aid to the Aged, Blind and Disabled Program recipient who became ineligible for SSI due to income but whose special needs entitled the recipient to an Aid to the Aged, Blind and Disabled Program payment as of December 1973.

(2) A mandatory state supplementation recipient shall be subject to the same payment requirements as specified in Section 4 of this administrative regulation.

(3) A mandatory state supplementation payment shall be equal to the difference between:

(a) The Aid to the Aged, Blind and Disabled Program payment for the month of December 1973; and

(b)1. The total of the SSI payment; or

2. The total of the SSI payment and other income for the current month.

(4) A mandatory payment shall discontinue if:

(a) The needs of the recipient as recognized in December 1973 have decreased; or

(b) Income has increased to the December 1973 level.

(5) The mandatory payment shall not be increased unless:

(a) Income as recognized in December 1973 decreases;

(b) The SSI payment is reduced, but the recipient’s circumstances are unchanged; or

(c) The standard of need as specified in Section 8 of this administrative regulation for a class of recipients is increased.

(6) If a husband and wife are living together, an income change after September 1974 shall not result in an increased mandatory payment unless total income of the couple is less than December 1973 total income.

Section 3. Optional State Supplementation Program. (1) Except as established in Sections 6, 7, and 8 of this administrative regulation, optional state supplementation shall be available to a person who meets technical requirements and resource limitations of the medically needy program for a person who is aged, blind, or has a disability in accordance with:

(a) 907 KAR 1:011, Sections 1(7), (8), 5(5), (6), (7), (13), 10, and 11;

(b) 907 KAR 1:640, Sections 1(1), (6), (7), (11), 3(4)(a);

(c) 907 KAR 1:645;

(d) 907 KAR 1:650, Section 1(9); and

(e) 907 KAR 1:660, Sections 1(1), (5), 2(1), (2), (3), and (4).

(2) A person shall apply or reapply for the state supplementation program in accordance with 921 KAR 2:035 and shall be required to:

(a) Furnish a Social Security number; or

(b) Apply for a Social Security number, if a Social Security number has not been issued.

(3) If potential eligibility exists for SSI, an application for SSI shall be mandatory.

(4) The effective date for state supplementation program approval shall be in accordance with 921 KAR 2:050.

Section 4. Optional State Supplementation Payment. (1) An optional state supplementation payment shall be issued in accordance with 921 KAR 2:050 for an eligible individual who:

(a) Requires a full-time living arrangement;

(b) Has insufficient income to meet the payment standards specified in Section 8 of this administrative regulation; and

(c)1. Resides in a personal care home and is eighteen (18) years of age in accordance with 902 KAR 20:041, Section 3(14); or

2. Resides in a family care home and is at least eighteen (18) years of age.

(2) A full-time living arrangement shall include:

(a) Residence in a personal care home that:

1. Meets the requirements and provides services established in 902 KAR 20:036; and

2. Is licensed under KRS 216B.010 to 216B.131;

(b) Residence in a family care home that:

1. Meets the requirements and provides services established in 902 KAR 20:041; and

2. Is licensed under KRS 216B.010 to 216B.131; or

(c) A situation in which a caretaker is required to be hired to provide care other than room and board.

(3) A guardian or other payee who receives a state supplementation check for a state supplementation recipient shall:

(a) Return the check to the Kentucky State Treasurer, the month after the month of:

1. Discharge to a: a. Nursing facility, unless the admission is for temporary medical care as specified in Section 9 of this administrative regulation; or

b. Residence; or

2. Death of the state supplementation recipient; and

(b) Notify a local county department office within five (5) working days of the death or discharge of the state supplementation recipient.

(4) Failure to comply with subsection (3)(a) of this section may result in prosecution in accordance with KRS Chapter 514.

(5) If there is no guardian or other payee, a personal care or family care home that receives a state supplementation check for a state supplementation recipient shall:

(a) Return the check to the Kentucky State Treasurer, the month after the month of:

1. Discharge to a:

a. Nursing facility, unless the admission is for temporary medical care as specified in Section 9 of this administrative regulation; or

b. Residence; or

2. Death of the state supplementation recipient; and

(b) Notify a local county department office within five (5) working days of the:

1. Death or discharge of the state supplementation recipient; or


(6) If a personal care or family care home receives a state supplementation check after voluntary relinquishment of a license, as specified in subsection (5)(b)2(a) of this section, the personal care or family care home shall return the check to the Kentucky State Treasurer.

(7) Failure to comply with subsections (5)(a) or (6) of this section may result in prosecution in accordance with KRS Chapter 514.

Section 5. Eligibility for Caretaker Services. (1) Service by a caretaker shall be provided to enable an adult to:

(a) Remain safely and adequately:

1. At home;

2. In another family setting; or

3. In a room and board situation; and

(b) Prevent institutionalization.

(2) Service by a caretaker shall be provided at regular intervals by:

(a) A live-in attendant; or

(b) One (1) or more persons hired to come to the home.

(3) Eligibility for caretaker supplementation shall be verified annually by the cabinet with the caretaker to establish how:

(a) Often the service is provided;

(b) The service prevents institutionalization; and

(c) Payment is made for the service.

(4) A supplemental payment shall not be made to or on behalf of an otherwise eligible individual if the:

(a) Client is taken daily or periodically to the home of the caretaker; or
(b) Caretaker service is provided by the following persons living with the applicant:
   1. The spouse;
   2. Parent of an adult or minor child who has a disability; or
   3. Adult child of a parent who is aged, blind or has a disability.

Section 6. Resource Consideration. (1) Except as stated in subsection (2) of this section, countable resources shall be determined according to policies for the medically needy in accordance with:
   (a) 907 KAR 1:640, Sections 1(1), (6), (7), (11), 3(4)(a);
   (b) 907 KAR 1:645;
   (c) 907 KAR 1:650, Section 1(9); and
   (d) 907 KAR 1:660, Sections 1(1), (5), 2(1), (2), (3), and (4).

(2) An individual or couple shall not be eligible if countable resources exceed the limit of:
   (a) $2000 for individual; or
   (b) $3000 for couple.

Section 7. Income Considerations. (1) Except as noted in subsections (2) through (8) of this section, income and earned income deductions shall be considered according to the policy for the medically needy in accordance with:
   (a) 907 KAR 1:640, Sections 1(1), (6), (7), (11), 3(4)(a); 
   (b) 907 KAR 1:645;
   (c) 907 KAR 1:650, Section 1(9); and
   (d) 907 KAR 1:660, Sections 1(1), (5), 2(1), (2), (3), and (4).

(2) The optional supplementation payment shall be determined by:
   (a) Adding:
      1. Total countable income of the applicant or recipient, or applicant or recipient and spouse; and
      2. A payment made to a third party on behalf of an applicant or recipient; and
   (b) Subtracting the total of paragraph (a)1 and 2 of this subsection from the standard of need in Section 8 of this administrative regulation.

(3) Income of an ineligible spouse shall be:
   (a) Adjusted by deducting sixty-five (65) dollars and one-half (1/2) of the remainder from the monthly earnings; and
   (b) Considered in the amount of one-half (1/2) of the SSI standard for an individual for:
      1. The applicant or recipient; and
      2. Each minor dependent child.

(4) Income of an eligible individual shall not be considered for the needs of the ineligible spouse or minor dependent child.

(5) Income of a child shall be considered if conserving the needs of the minor dependent child so the amount conserved does not exceed the allowable amount.

(6) The earnings of the eligible individual and ineligible spouse shall be combined prior to the application of the earnings disregard of sixty-five (65) dollars and one-half (1/2) of the remainder.

(7) If treating a husband and wife who reside in the same personal care or family care home as living apart prevents them from receiving state supplementation, the husband and wife may be considered to be living with each other.

(8) The SSI twenty (20) dollars general exclusion shall not be an allowable deduction from income.[90(a)] For a resident in the Elder Shelter Network Program, income and resources of the spouse shall be disregarded for the month of separation.

(b) A third party payment on behalf of an applicant or recipient made by the Elder Shelter Network Program shall be disregarded for ninety (90) days from the date of admission.

Section 8. Standard of Need. (1) To the extent funds are available, the standard of need is as follows:
   (a) For a resident of a personal care home on or after January 1, 2013, $1,277[2012, $1,198];
   (b) For a resident of a family care home on or after January 1, 2013, $892[2012, $820]; or
   (c) For individuals who receive caretaker services:
      1. A single individual, or an eligible individual with an ineligible spouse who is not aged, blind, or has a disability on or after January 1, 2013, $772[2012, $720];

(b) An eligible couple, both aged, blind, or have a disability and one (1) requiring care on or after January 1, 2013, $1,127[2012, $1,100]; or

(2) In a couple case, if both are eligible, the couple's income shall be combined prior to comparison with the standard of need.

(b) One-half (1/2) of the deficit shall be payable to each.

(3) A personal care home shall accept full payment for cost of care the amount of the standard, based on the living arrangement, minus a sixty (60) dollars personal needs allowance that shall be retained by the client.

(4) A family care home shall accept full payment for cost of care the amount of the standard, based on the living arrangement, minus a forty (40) dollars personal needs allowance that shall be retained by the client.

Section 9. Temporary Stay in a Medical Facility. (1) An SSI recipient who receives optional or mandatory state supplementation shall have continuation of state supplementation benefits without interruption for the first three (3) full months of medical care in a health care facility if:
   (a) The non-SSI recipient meets the requirements of subsection (1)(c) of this section;
   (b) A physician certifies, in writing, that the non-SSI recipient is not likely to be confined for longer than ninety (90) full consecutive days;
   (c) A guardian or other payee, personal care home, or family care home, receiving a state supplementation check for the state supplementation recipient, provides a local county department office with:
      1. Notification of the temporary admission; and
      2. The physician statement specified in paragraph (b) of this subsection.

(3) A temporary admission shall be limited to the following health care facilities:
   (a) Hospital;
   (b) Psychiatric hospital; or
   (c) Nursing facility.

(4) If a state supplementation recipient is discharged in the month following the last month of continued benefits, the temporary absence shall continue through the date of discharge.

Section 10. Citizenship requirements. An applicant or recipient shall be:
   (1) Citizen of the United States; or
   (2) Qualified alien.

Section 11. Requirement for Residency. An applicant or recipient shall reside in Kentucky.

Section 12. Mental Illness or Mental Retardation (MI/MR) Supplement Program. (1) A personal care home:
   (a) May qualify, to the extent funds are available, for a quarterly supplement payment of fifty (50) cents per diem for a state supplementation recipient in the personal care home's care as of the first calendar day of a qualifying month;
   (b) Shall not be eligible for a payment for a Type A Citation that is not corrected; and
   (c) Shall meet the following certification criteria for eligibility to participate in the MI/MR Supplement Program:
      1. Be licensed in accordance with KRS 216B.010 to 216B.131;
2. Care for a population that is thirty-five (35) percent mental illness or mental retardation clients in all of its occupied licensed personal care home beds and who have a: 
   a. Primary or secondary diagnosis of mental retardation including mild or moderate, or other ranges of retardation whose needs can be met in a personal care home; 
   b. Primary or secondary diagnosis of mental illness excluding organic brain syndrome, senility, chronic brain syndrome, Alzheimer’s, and similar diagnoses; or 
   c. Medical history that includes a previous hospitalization in a psychiatric facility, regardless of present diagnosis; 
3. Have a licensed nurse or an individual who has received and successfully completed certified medication technician training on duty for at least four (4) hours during the first or second shift each day; 
4. Not decrease staffing hours of the licensed nurse or individual who has successfully completed certified medication technician training in effect prior to July 1990, as a result of this minimum requirement; 
5. Be verified by the Office of Inspector General in accordance with Section 14(2) through (4) of this administrative regulation; and 
6. File an STS-1, Mental Illness or Mental Retardation (MI/MR) Supplement Program Application for Benefits, with the department by the tenth working day of the first month of the calendar quarter to be eligible for payment in that quarter. 
   a. Quarters shall begin in January, April, July and October; 
   b. Unless mental illness or mental retardation supplement eligibility is discontinued, a new application for the purpose of program certification shall not be required. 
(2) A personal care home shall provide the department with its tax identification number and address as part of the application process. 
(3) The department shall provide an STS-2, Mental Illness or Mental Retardation (MI/MR) Supplement Program Notice of Decision to Personal Care Home to a personal care home following: 
   (a) Receipt of verification from the Office of Inspector General as specified in Section 14(6) of this administrative regulation; and 
   (b) Approval or denial of an application. 
(4) A personal care home shall: 
   (a) Provide the department with an STS-3, Mental Illness or Mental Retardation (MI/MR) Supplement Program Monthly Report Form that: 
      1. Lists every resident of the personal care home who was a resident on the first day of the month; 
      2. Lists the resident’s Social Security number; and 
      3. Annotates the form, in order to maintain confidentiality, as follows with a: 
         a. Star indicating a resident has a mental illness or mental retardation diagnosis; 
         b. Check mark indicating a resident receives state supplementation; and 
         c. Star and a check mark indicating the resident has a mental illness or mental retardation diagnosis and is a recipient of state supplementation; and 
   (b) Submit the STS-3 to the department on or postmarked by the fifth working day of the month by: 
      1. Mail; 
      2. Fax; or 
      3. Electronically. 
(5) The monthly report shall be used by the department for: 
   (a) Verification as specified in subsection (4)(a) of this section; 
   (b) Payment; and 
   (c) Audit purposes. 
(6)(a) A personal care home shall notify the department within ten (10) working days if its mental illness or mental retardation percentage goes below thirty-five (35) percent for all personal care residents. 
   (b) A personal care home may be randomly audited by the department to verify percentages and payment accuracy. 

Section 13. Mental Illness or Mental Retardation Basic Training. (1)(a) To the extent cabinet funds are available to support the training, a personal care home’s licensed nurse, or individual who has successfully completed certified medication technician training shall attend the mental illness or mental retardation basic training workshop provided through the Department for Behavioral Health, Developmental and Intellectual Disabilities. 
   (b) Other staff may attend the basic training workshop in order to assure the personal care home always has at least one (1) certified staff employed for certification purposes. 
(2) The mental illness or mental retardation basic training shall be provided through a one (1) day workshop. The following topics shall be covered: 
   (a) Importance of proper medication administration; 
   (b) Side effects and adverse medication reactions with special attention to psychotropics; 
   (c) Signs and symptoms of an acute onset of a psychiatric episode; 
   (d) Characteristics of each major diagnosis, for example, paranoia, schizophrenia, bipolar disorder, or mental retardation; 
   (e) Guidance in the area of supervision versus patient rights for the population with a diagnosis of mental illness or mental retardation; and 
   (f) Instruction in providing a necessary activity to meet the needs of a resident who has a diagnosis of mental illness or mental retardation. 
(3) Initial basic training shall: 
   (a) Include the licensed nurse or the individual who has successfully completed certified medication technician training and may include the owner or operator; and 
   (b) Be in the quarter during which the STS-1 is filed with the department. 
(4) To assure that a staff member who has received basic training is always employed at the personal care home, a maximum of five (5) may be trained during a year. 
   (a) If staff turnover results in the loss of the licensed nurse or individual who has successfully completed certified medication technician training and four (4) other staff have been trained, the personal care home shall request in writing to the department an exemption of the five (5) staff maximum, in order to train another staff member. 
   (b) A personal care home shall have on staff a licensed nurse or individual who: 
      1. Has successfully completed certified medication technician training; or 
      2. a. Has received mental illness or mental retardation basic training; or 
          b. Is enrolled in the next scheduled mental illness or mental retardation basic training workshop at the closest location. 
(5) The Department for Behavioral Health, Developmental and Intellectual Disabilities may provide advanced level training for a personal care home. 
   (a) Advanced level training shall be provided through a one (1) day workshop. 
   (b) Each advanced level workshop shall consist of two (2) sessions per day, and each session shall be three (3) hours in duration. 
   (c) Each three (3) hour session shall cover a topic appropriate for staff who work with a resident who has a diagnosis of mental illness or mental retardation. 
   (d) Attendance of an advanced level training workshop shall be optional. 
(6) The Department for Behavioral Health, Developmental and Intellectual Disabilities shall provide within five (5) working days a: 
   (a) Certificate to direct care staff who complete the training workshop; and 
   (b) Listing to the department of staff who completed the training workshop. 
(7) Unless staff turnover occurs as specified in subsection (4)(a) of this section, the department shall pay twenty-five (25) dollars, to the extent funds are available, to a personal care home: 
   (a) That has applied for the MI/MR Supplement Program; and 
   (b) For each staff member receiving basic or advanced level training up to the maximum of five (5) staff per year. 
(8) Attendance of the basic training workshop shall be optional for a specialized personal care home. 

Section 14. MI/MR Supplement Program Certification. (1) The
Office of the Inspector General shall visit a personal care home to certify eligibility to participate in the MI/MR Supplement Program.

(a) The personal care home's initial MI/MR Supplement Program Certification Survey:

1. May be separate from an inspection conducted in accordance with KRS 216.530; and
2. Shall be in effect until the next licensure survey.

(b) After a personal care home’s initial MI/MR Supplement Program Certification Survey is completed, the personal care home may complete any subsequent certification survey during the licensure survey as specified in paragraph (a)(2) of this subsection.

(c) The department shall notify the Office of Inspector General that the personal care home is ready for an inspection for eligibility.

(2) During the eligibility inspection, the Office of Inspector General shall:

(a) Observe and interview residents and staff; and
(b) Review records to assure the following criteria are met:
1. Except for a specialized personal care home, certification is on file at the personal care home to verify staff's attendance of basic training, as specified in Section 13(1) through (4) of this administrative regulation;
2. The personal care home:
   a. Has certified staff training all other direct care staff through in-service training or orientation regarding the information obtained at the mental illness or mental retardation basic training workshop; and
   b. Maintains documentation of attendance at the in-service training for all direct care staff;
3. Medication administration meets licensure requirements and a licensed nurse or individual who has successfully completed certified medication technician training:
   a. Demonstrates a knowledge of psychotropic drug side effects; and
   b. Is on duty as specified in Section 12(1)(c)3 of this administrative regulation; and
4. An activity is being regularly provided that meets the needs of a resident.
   a. If a resident does not attend a group activity, an activity shall be designed to meet the needs of the individual resident, for example, reading or other activity that may be provided on an individual basis.
   b. An individualized care plan shall not be required for the criteria in clause a. of this subparagraph.

(3) The Office of Inspector General shall review the personal care home copy of the training certification prior to performing a record review during the MI/MR Supplement Program Certification Survey process.

(a) If thirty-five (35) percent of all occupied personal care beds in the facility, the personal care home shall notify the department as specified in Section 12(1)(c)2 of this administrative regulation, on the day of the visit, a personal care home shall be deemed to have an ongoing qualifying percentage effective with month of request for certification as specified in subsection (1)(c) of this section.

(b) If the mental illness or mental retardation population goes below thirty-five (35) percent of all occupied personal care beds in the facility, the personal care home shall notify the department as specified in Section 12(6)(a) of this administrative regulation.

(6) The Office of Inspector General shall provide the department with a completed STS-4, Mental Illness or Mental Retardation (MI/MR) Supplement Certification Survey within fifteen (15) working days of an:

(a) Initial survey; or
(b) Inspection in accordance with KRS 216.530.

(7) The Office of Inspector General shall provide a copy of a Type A Citation issued to a personal care home to the department by the fifth working day of each month for the prior month.

The personal care home shall receive a reduced payment for the number of days the Type A Citation occurred on the first administratively feasible quarter following notification by the Office of Inspector General, in accordance with 921 KAR 2:050.

(9) If a criterion for certification is not met, the department shall issue an STS-2 to a personal care home following receipt of the survey by the Office of Inspector General as specified in subsection (6) of this section.

(10) The personal care home shall provide the department with the information requested on the STS-2:

(a) Relevant to unmet certification criteria specified on the STS-4; and
(b) Within ten (10) working days after the STS-2 is issued.

(11) If a personal care home fails to provide the department with the requested information specified in subsection (10) of this section, assistance shall be discontinued or decreased, pursuant to 921 KAR 2:046.

(12) If a personal care home is discontinued from the MI/MR Supplement Program, the personal care home may reapply for certification, by filing an STS-1 in accordance with Section 12(1)(c)6 of this administrative regulation, for the next following quarter.

Section 15. Hearings and Appeals. An applicant or recipient of benefits under a program described in this administrative regulation who is dissatisfied with an action or inaction on the part of the cabinet shall have the right to a hearing under 921 KAR 2:055.

Section 16. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) “STS-1, Mental Illness or Mental Retardation (MI/MR) Supplement Program Application for Benefits”, edition 1/09;
(b) “STS-2, Mental Illness or Mental retardation (MI/MR) Supplement Program Notice of Decision to Personal Care Home”, edition 1/09;
(c) “STS-3, Mental Illness or Mental Retardation (MI/MR) Supplement Program Monthly Report Form”, edition 1/09; and
(d) “STS-4, Mental Illness or Mental Retardation (MI/MR) Supplement Certification Survey”, edition 1/12.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

TERESA C. JAMES, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 11, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2013 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments regarding this proposed administrative regulation until close of business February 28, 2013.

Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Justin Dearinger

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes a program for supplemental payments to persons requiring care in a personal care or family care home or receiving caretaker services in accordance with KRS 205.245.
(b) The necessity of this administrative regulation: This administrative regulation is needed to establish conditions and requirements regarding the State Supplementation Program and the Mental Illness or Mental Retardation (MI/MR) Supplement Program.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the authorizing statutes through its establishment of a supplemental program for persons who are aged, blind or have a disability. Failure to comply with this administrative regulation will result in the loss of Federal Funds/Agency Funds. The purpose of the program is to ensure that recipients of the Supplemental Security Income (SSI) Program are not deprived of needed medical, support, or other necessary services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the eligibility requirements and standards of need for the State Supplementation Program for persons who are aged, blind or have a disability.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation; the amendment to this administrative regulation will increase the standards of need for all levels of care in the State Supplementation Program for persons who are aged, blind or have a disability. The increase reflects the cost of living adjustment to be implemented in calendar year 2013 by the Social Security Administration for Supplemental Security Income (SSI) recipients. The amendment also makes technical corrections.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to comply with the agreement between the Commonwealth of Kentucky and the Social Security Administration, formerly a part of the U.S. Department of Health, Education, and Welfare, to pass along the cost of living adjustment in Supplemental Security Income (SSI) benefits to State Supplementation Program recipients.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to authorizing statutes by modifying the standards of need for all levels of care in the State Supplementation Program and making other technical corrections.
(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the statutes by passing along the cost of living adjustment for Supplemental Security Income (SSI) benefits to State Supplementation Program recipients.
(e) How the amendment is necessary to comply with the agreement between the Commonwealth of Kentucky and the Social Security Administration: The Social Security Administration notified the Department of Community Based Services of the amount of the Supplemental Security Income (SSI) cost of living adjustment in October 2012. Technical corrections were necessary in accordance with KRS Chapter 13A and to reflect enacted legislation and the closure of the Elder Shelter Network.
(f) How this administrative regulation conforms to the content of the authorizing statutes: The amendment conforms to authorizing statutes by complying with an agreement between Kentucky and the federal government to pass along the cost of living adjustment for Supplemental Security Income (SSI) benefits to State Supplementation Program recipients. Failure to comply with this administrative regulation jeopardizes the state’s Medicaid funds pursuant to 20 C.F.R. 416.2099. The Social Security Administration notified the Department for Community Based Services of the amount of the Supplemental Security Income (SSI) cost of living adjustment in October 2012. Technical corrections were necessary in accordance with KRS Chapter 13A and to reflect enacted legislation and the closure of the Elder Shelter Network.
(g) How this administrative regulation conforms to the content of the authorizing statutes: The amendment conforms to authorizing statutes by modifying the standards of need for all levels of care in the State Supplementation Program and making other technical corrections.
(h) The necessity of the amendment to this administrative regulation: This amendment is necessary to comply with the agreement between the Commonwealth of Kentucky and the Social Security Administration, formerly a part of the U.S. Department of Health, Education, and Welfare, to pass along the cost of living adjustment in Supplemental Security Income (SSI) benefits to State Supplementation Program recipients.
(i) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to authorizing statutes by modifying the standards of need for all levels of care in the State Supplementation Program and making other technical corrections.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate: 42 U.S.C. 1382e-g.

2. State compliance standards. KRS 194A.050 (1), 205.245

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1382e-g

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation does not impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose a stricter standard, or additional or different responsibilities or requirements, than those required by the federal mandate.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Community Based Services will be impacted by this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.050 (1), 205.245, 42 U.S.C. 1382e-g

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first year? This amendment will not generate additional revenue in the first year.

4. How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate any additional revenue in subsequent years.

5. How much will it cost to administer this program for the first year? No additional costs are necessary to administer this program during the first year.
(d) How much will it cost to administer this program for subsequent years? No additional costs are necessary to administer this program during subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:
GENERAL GOVERNMENT CABINET
Board of Nursing
(Repealer)


RELATES TO: KRS 314.073
STATUTORY AUTHORITY: KRS 314.131(1)
NECESSITY, FUNCTION, AND CONFORMITY: 201 KAR 20:200 and 201 KAR 20:380 are being repealed because they are being added to 201 KAR 20:220.

Section 1. The following administrative regulations are hereby repealed:
(1) 201 KAR 20:200, Definitions for mandatory continuing education; and
(2) 201 KAR 20:380, Standards for refresher course approval.

SALLY BAXTER, President
APPROVED BY AGENCY: October 11, 2012.
FILED WITH LRC: January 10, 2013 at 1 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 26, 2013 at 1:00 p.m. (EST) in the office of the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky. Individuals interested in being heard at this hearing shall notify this agency in writing by February 19, 2012, five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until close of business February 28, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Nathan Goldman, General Counsel, Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40224, phone (502) 429-3309, fax (502) 564-4251, email nathan.goldman@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT
Contact Person: Nathan Goldman
(1) Provide a brief summary of:
(a) What this administrative regulation does: It repeals administrative regulations 201 KAR 20:200 and 201 KAR 20:380.
(b) The necessity of this administrative regulation: 201 KAR 20:200 and 201 KAR 20:380 are being moved into 201 KAR 20:220. Most of the definitions in 201 KAR 20:200 are no longer in the administrative regulations. The remaining ones are being moved to 201 KAR 20:220. The provisions concerning the refresher course approval are substantially the same as other continuing education providers, so are being moved to 201 KAR 20:220 as well.
(c) How this administrative regulation conforms to the content of the authorizing statutes: Administrative regulations that are no longer necessary must be repealed.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By repealing unnecessary regulations.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This is not an amendment.
(b) The necessity of the amendment to this administrative regulation:

(c) How the amendment conforms to the content of the authorizing statutes: N/A
(d) How the amendment will assist in the effective administration of the statutes: N/A
(e) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Applicants who wish to establish a refresher course, number unknown.
(f) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: This is a repealer regulation.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This is a repealer regulation.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This is a repealer regulation.
(d) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
(a) Initially: There is no additional cost.
(b) On a continuing basis: There is no additional cost.
(c) State whether or not this administrative regulation establishes any fees or directly or indirectly increased any fees: It does not.
(9) TIERING: Is tiering applied? Tiering was not applied as the changes apply to all equally.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT
(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation?
Kentucky Board of Nursing
(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 13A.310
(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None
(c) How much will it cost to administer this program for the first year? No additional cost
(d) How much will it cost to administer this program for subsequent years? No additional cost
Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-):
Expenditures (+/-):
Other Explanation:
TOURISM, ARTS AND HERITAGE CABINET
Kentucky Historical Society
(New Administrative Regulation)

300 KAR 5:010. Museum unclaimed property.

RELATES TO: KRS 171.830 - 171.849
STATUTORY AUTHORITY: KRS 171.849
NECESSITY, FUNCTION, AND CONFORMITY: KRS 171.849 requires the Kentucky Historical Society to promulgate administrative regulations relating to property on loan to museums in Kentucky. This administrative regulation establishes procedures for museums to follow to acquire title of unclaimed property in the museums’ possession.

Section 1. Definitions. (1) “Conservation measures” means stabilization of an object or specimen that is in the possession of the museum according to the conservation and restoration guidelines established by the ICOM Code of Ethics.
(2) “ICOM” means International Council of Museums.
(3) “KHS” means Kentucky Historical Society.
(4) “Publication” or “publicize” means notification to the public in an effort to locate the owner of unclaimed property in either print or electronic online format in accordance with KRS 171.840(2)(c).
(5) “Unclaimed Property” means a tangible object in the custody of the museum that:
(a) Has intrinsic historical, artistic, scientific, or cultural value; and
(b) Whose owner is unknown or has failed to claim the object.

Section 2. Notice of Intent to Gain Title to Property. A museum shall attempt to provide the following notice to the owner of property on loan or property otherwise held by the museum if it intends to gain title to the property in accordance with KRS 171.836:
(1) Notice of Intent to Gain Title to Property, Form #1; or
(2) A notice developed by the museum which meets the requirements of KRS 171.840.

Section 3. Written Assertion of Title to Property. A person who has received a Notice of Intent to Gain Title to Property form or other written notice complies with KRS 171.840 shall file the following with the museum to assert title to the property on loan or property otherwise held by the museum in accordance with KRS 171.843:
(1) Written Assertion of Title to Property, Form #2; or
(2) A written assertion of title developed by the person which:
(a) Describes the property in detail;
(b) Describes the person’s interest in the property;
(c) Attaches copies of documents supporting the person’s assertion of an interest in the property; and
(d) Includes a sworn statement that the information presented is true and complete to the best of the person’s knowledge.

Section 4. Kentucky Historical Society. (1) KHS shall maintain and post on the KHS Web site the following public information relating to the handling and conservation of unclaimed museum property:
(a) A copy of or electronic link to KRS 171.830 through KRS 171.849;
(b) A copy of or electronic link to 300 KAR 5:010; and
(c) A copy of or electronic link to ICOM Code of Ethics.
(2) KHS shall publicize attempts by museums statewide to gain clear title to unclaimed property on the KHS Web site.
(3) Museums shall mail or email the KHS Registrar a written request to publicize the museum’s attempts to gain title to unclaimed property and:
(a) A copy of the Notice of Intent to Gain Title to Property form; or
(b) A copy of the newspaper notification demonstrating the museum has followed the steps as outlined in KRS 171.840(2)(c).
(4) KHS shall post within ten (10) business days unclaimed property information submitted by a museum for a minimum of two (2) consecutive weeks on the KHS Web site.

Section 5. Conservation. Kentucky museums shall use conservation measures for property on loan to the museum.

Section 6. Incorporation by Reference. (1) The following material is incorporated by reference:
(b) “Notice of Intent to Gain Title to Property”, Form #1, 2013 Edition; and
(c) “Written Assertion of Title to Property”, Form #2, 2013 Edition.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at Kentucky Historical Society, 100 West Broadway, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

KENT WHITWORTH, Executive Director
MARCHETA SPARROW, Secretary
APPROVED BY AGENCY: January 14, 2013
FILED WITH LRC: January 14, 2013 at 1 p.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 22, 2013 at 10:00 am Eastern Time at the 500 Mero Street, 24th Floor Conference Room, Frankfort Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by five (5) working days prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at this public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Misty Judy, Legal Counsel, Office of Legal Affairs, Tourism, Arts and Heritage Cabinet, 500 Mero Street, 24th Floor, Frankfort Kentucky 40601, phone (502) 564-4270, fax (502) 564-1079.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Misty Dugger Judy
(1) Provide a brief summary of:
(a) What this administrative regulation does; This administrative regulation establishes guidelines to assist Kentucky museums regarding the conserving and handling of abandoned property on loan to the museum.
(b) The necessity of the administrative regulation: This administrative regulation is necessary to ensure proper handling by Kentucky museums of abandoned property on loan to the museum.
(c) How this administrative regulation conforms to the consent of the authorizing statutes: KRS 141.849 mandates that administrative regulations be promulgated and outlines the procedures to acquire and conserve abandoned museum property.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: Currently the statute does not outline steps on conservation and handling of abandoned property. This administrative regulation will assist Kentucky museums to publish and provide notice that an item on loan is unclaimed and give the public the opportunity to claim the item.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: N/A
(b) The necessity of the amendment to this administrative regulation: N/A
(c) How the amendment conforms to the content of the authorizing statutes: N/A
(d) How the amendment will assist in the effective administration of the statutes: N/A
(3) List the type and number of individuals, businesses, organi-
zations, or state and local governments affected by this administrative regulation: The Kentucky Historical Society, museums, historical societies, historical sites and landmarks, parks, and libraries located in Kentucky.

(4) An analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, it if is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: All museums will use conservation measures according to the guidelines of the International Council of Museums Code of Ethics. Those museums attempting to gain title to unclaimed property may have to increase publication efforts by submitting a written request for additional online publication by the Kentucky Historical Society (KHS) of the museums’ attempt to gain title of abandoned property by publishing on the KHS website a copy of the newspaper notice required by KRS 171.840(2). (c).

(b) Determine the administrative regulation or amendment, how much it will cost each of the entities identified in question (3): Cost of publication only occurs if museum voluntarily chooses to exercise an attempt to gain title to abandoned property.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The procedures outlined in ICOM code of ethics will assist Kentucky museums in maintaining unclaimed property, and KHS will more efficiently provide publication notices for unclaimed properties to the public.

(5) Provide an estimate of how much it will cost the administrative body to implement the administrative regulation:

(a) Initially: No additional other than minor administrative costs; No other cost for implementation.

(b) On a continuing basis: No additional cost on a continuing basis.

(6) What is the source of the funding to be used for the implementation, and enforcement of this administrative regulation: No additional cost.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in funding will be necessary.

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county where the child’s DCBS case is located.

(5)(a) During the department’s implementation of managed care in accordance with this administrative regulation, the department shall assign a recipient to an MCO based upon an algorithm that considers:
1. Continuity of care; and
2. Enrollee preference of an MCO provider.
(b) An assignment shall focus on a need of a child or an individual with a special health care need.
(6)(a) A newly eligible recipient or a recipient who has had a break in eligibility of greater than two (2) months shall have an opportunity to choose an MCO during the eligibility application process.
(b) If a recipient does not choose an MCO during the eligibility application process, the department shall assign the recipient to an MCO.

(7) Each member of a household shall be assigned to the same MCO.

(8) The effective date of enrollment for a recipient described in subsection (6) of this section shall be:
(a) The date of Medicaid eligibility; and
(b) No earlier than January 1, 2013 for region three.
(9) A recipient shall be given a choice of MCOs.
(10) An MCO enrolled with an MCO who loses Medicaid eligibility for less than two (2) months shall be automatically reenrolled with the same MCO upon redetermination of Medicaid eligibility unless the recipient moves outside of the MCO’s regional coverage.
(11) A newborn who has been deemed eligible for Medicaid shall be automatically enrolled with the newborn’s mother’s MCO as an individual enrollee for up to sixty (60) days.
(12)(a) An enrollee may change an MCO for any reason, regardless of whether the MCO was selected by the enrollee or assigned by the department:
1. Within ninety (90) days of the effective date of enrollment;
2. Annually during an open enrollment period;
3. Upon automatic enrollment under subsection (10) of this section, if a temporary loss of Medicaid eligibility caused the recipient to miss the annual opportunity in subparagraph 2. of this paragraph; or
(b) An MCO shall accept an enrollee who changes MCOs under this section.
(13) Only the department shall have the authority to enroll a Medicaid recipient with an MCO in accordance with this section.
(14) Upon enrollment with an MCO, an enrollee shall receive two (2) identification cards.
(a) A card shall be issued from the department that shall verify Medicaid eligibility.
(b) A card shall be issued by the MCO that shall verify enrollment with the MCO.
(15)(a) Within five (5) business days after receipt of notification of a new enrollee, an MCO shall send, by a method that shall not take more than three (3) days to reach the enrollee, a confirmation letter to an enrollee.
(b) The confirmation letter shall include at least the following information:
1. The effective date of enrollment;
2. The name, location, and contact information of the PCP;
3. How to obtain a referral;
4. Care coordination;
5. The benefits of preventive health care;
6. The enrollee identification card;
7. A member handbook; and
8. A list of covered services.
(16) Enrollment with an MCO shall be without restriction.
(17) An MCO shall:
(a) Have continuous open enrollment for new enrollees; and
(b) Accept enrollees regardless of overall enrollment.
(18)(a) Except as provided in paragraph (b) through (e) of this subsection, a recipient eligible to enroll with an MCO shall be enrolled beginning with the first day of the month that the enrollee applied for Medicaid.
(b) A newborn shall be enrolled beginning with the newborn’s date of birth.
(c) An unemployed parent shall be enrolled beginning with the date the unemployed parent met the definition of unemployment in accordance with 45 C.F.R. 233.100.
(d)1. If an enrollee is retroactively determined eligible for Medicaid, the retroactive eligibility, except for an individual who has been determined to be eligible for SSI benefits, shall be for a period up to three (3) months prior to the month that the enrollee applied for Medicaid.
2. Except as established in paragraph (f) of this subsection, an MCO shall be responsible for reimbursing for covered services provided to a retroactively determined eligible individual referenced in subparagraph 1. of this paragraph during the individual’s retroactive eligibility period.
(e) If an enrollee is retroactively determined eligible for Medicaid as a result of being determined retroactively eligible for SSI benefits:
1. The individual’s enrollment date with an MCO shall be the first of the month following the month in which the department is notified of the individual’s retroactive eligibility for SSI benefits; and
2. The department shall be responsible for reimbursing for any services provided during the retroactive eligibility period for an individual determined to be retroactively eligible for SSI benefits.
(f) In addition to the reimbursement obligation described in paragraph (e)2. of this subsection, the department shall be responsible for reimbursing for services provided to an individual:
1. Determined to be retroactively eligible for any portion of the retroactive eligibility period which occurred prior to November 1, 2011 for regions one (1), two (2), four (4), five (5), six (6), seven (7) and eight (8) if the individual has a retroactive eligibility period prior to November 1, 2011; or
2. Determined to be retroactively eligible for any portion of the retroactive eligibility period which occurred prior to January 1, 2013 for region three (3) if the individual has a retroactive eligibility period prior to January 1, 2013.
(g) The policy stated in paragraph (e)2. and (f)2. of this subsection shall be effective January 1, 2013.
(19) For an enrollee whose eligibility resulted from a successful appeal of a denial of eligibility, the enrollment period shall begin:
1. On the first day of the month of the original application for eligibility; or
2. On the first day of the month of retroactive eligibility as referenced in subsection (18)(d) or (e) of this section, if applicable; and
(b) No earlier than:
1. November 1, 2011 for regions one (1), two (2), four (4), five (5), six (6), seven (7), and eight (8); or
2. January 1, 2013 for region three (3).
(20) A provider shall be responsible for verifying an individual’s eligibility for Medicaid and enrollment in a managed care organization when providing a service.

Section 2. Disenrollment. (1) The policies established in 42 C.F.R. 438.56 shall apply to an MCO.
(2) Only the department shall have the authority to disenroll a recipient from an MCO.
(3) A disenrollment of a recipient from an MCO shall:
(a) Become effective on the first day of the month following disenrollment; and
(b) Occur:
1. If the enrollee:
   a. No longer resides in an area served by the MCO;
   b. Becomes incarcerated or deceased; or
   c. Is exempt from managed care enrollment in accordance with Section 1(3) of this administrative regulation; or
2. In accordance with 42 C.F.R. 438.56.
(4) An MCO may recommend to the department that an enrollee be disenrolled if the enrollee:
(a) Is found guilty of fraud in a court of law or administratively determined to have committed fraud related to the Medicaid Program;
(b) Is abusive or threatening but not for uncooperative or disruptive behavior resulting from his or her special needs (except if his or her continued enrollment in the MCO seriously impairs the
entity’s ability to furnish services to either this particular enrollee or other enrollees) pursuant to 42 C.F.R. 438.56(b)(2);
(c) Becomes deceased; or
(d) No longer resides in an area served by the MCO.
(3) An enrollee shall not be disenrolled by the department, nor shall the managed care organization recommend disenrollment of an enrollee, due to an adverse change in the enrollee’s health.
(6)(a) An approved disenrollment shall be effective no later than the first day of the second month following the month the enrollee or the MCO files a request in accordance with 42 C.F.R. 438.56(e)(1).
(b) If the department fails to make a determination within the timeframe specified in paragraph (a) of this subsection, the disenrollment shall be considered approved in accordance with 42 C.F.R. 438.56(e)(2).
(7) If an enrollee is disenrolled from an MCO, the:
(a) Enrollee shall be enrolled with a new MCO if the enrollee is:
1. Eligible for Medicaid; and
2. Not excluded from managed care participation; and
(b) MCO shall:
1. Assist in the selection of a new primary care provider, if requested;
2. Cooperate with the new primary care provider in transitioning the enrollee’s care; and
3. Make the enrollee’s medical record available to the new primary care provider in accordance with state and federal law.
(8) An MCO shall notify the department or Social Security Administration in an enrollee’s county of residence within five (5) working days of receiving notice of the death of an enrollee.

Section 3. Enrollee Rights and Responsibilities. (1) An MCO shall have written policies and procedures:
(a) To protect the rights of an enrollee that includes the:
1. Protection against liability for payment in accordance with 42 U.S.C. 1396u-2(b)(6);
2. Rights specified in 42 C.F.R. 438.100;
3. Right to prepare an advance medical directive pursuant to KRS 311.621 through KRS 311.643;
4. Right to choose and change a primary care provider;
5. Right to file a grievance or an appeal;
6. Right to receive assistance in filing a grievance or an appeal;
7. Right to a state fair hearing;
8. Right to a timely referral and access to medically indicated specialty care; and
9. Right to access the enrollee’s medical records in accordance with federal and state law; and
(b) Regarding the responsibilities of enrollees that include the responsibility to:
1. Become informed about:
   a. Enrollee rights specified in paragraph (a) of this subsection; and
   b. Service and treatment options;
2. Abide by the MCO’s and department’s policies and procedures;
3. Actively participate in personal health and care decisions;
4. Report suspected fraud or abuse; and
5. Keep appointments or call to cancel if unavaiable to keep an appointment.
(2) The information specified in subsection (1) of this section shall meet the information requirements established in 42 C.F.R. 438.10.

Section 4. MCO Internal Appeal Process. (1) An MCO shall have written policies and procedures describing how an enrollee shall submit a request for:
(a) A grievance with the MCO;
(b) An appeal with the MCO; or
(c) A state fair hearing in accordance with KRS Chapter 13B.
(2) An enrollee shall have thirty (30) calendar days from the date of an event causing dissatisfaction to file a grievance orally or in writing with the MCO.
(a) Within five (5) working days of receipt of a grievance, an MCO shall provide the enrollee with written notice that the grievance has been received and the expected date of its resolution.
(b) An investigation and final resolution of a grievance shall:
1. Be completed within thirty (30) calendar days of the date the grievance is received by the MCO; and
2. Include a resolution letter to the enrollee that shall include:
   a. All information considered in investigating the grievance;
   b. Findings and conclusions based on the investigation; and
   c. The disposition of the grievance.
(3) An MCO shall have an internal appeal process in place that allows an enrollee to challenge a denial of coverage of, or payment for, a service in accordance with 42 C.F.R. 438.400 through 438.424 and 42 U.S.C. 1396u-2(b)(4).
(4)(a) A provider shall not be an authorized representative of an enrollee without the enrollee’s written consent for the specific action that is being appealed or that is the subject of a state fair hearing.
   (b) The written consent referenced in paragraph (a) of this subsection shall be signed and dated by the enrollee no earlier than the first day of the second month following the month the enrollee or the MCO files a request to file an appeal on behalf of the enrollee.
   (6) An enrollee shall have thirty (30) calendar days from the date of an appeal to file an appeal with the MCO; and
   (7) An MCO shall resolve an appeal within thirty (30) calendar days from the date the initial oral or written appeal is received by the MCO.
(5) A legal guardian of an enrollee who is a minor or an incapacitated adult or an authorized representative of an enrollee in accordance with subsection (4) of this section shall have the right to file a complaint with the department.
(10)(a) Within five (5) working days of receipt of an appeal, an MCO shall provide the enrollee with written notice that an appeal has been received and the expected date of its resolution.
(11) An MCO shall extend the thirty (30) day timeframe for resolution of an appeal established in subsection (7) of this section by fourteen (14) calendar days if:
   (a) The enrollee requests the extension; or
   (b)1. The MCO demonstrates to the department that there is need for additional information; and
    2. The extension is in the enrollee’s interest.
(12) For an extension requested by an MCO, the MCO shall provide the enrollee written notice of the extension and the reason for the extension within two (2) working days of the decision to extend.
(13)(a) For an appeal, an MCO shall provide written notice of its decision within thirty (30) calendar days to an enrollee or a provider, if the provider filed the appeal.
   (b) The provider shall:
    1. Give a copy of the notice to the enrollee; or
    2. Inform the enrollee of the provisions of the notice.
(14) An MCO shall:
   (a) Continue to provide benefits to an enrollee, if the enrollee requested a continuation of benefits, until one (1) of the following occurs:
    1. The enrollee withdraws the appeal;
    2. Fourteen (14) days have passed since the date of the resolution letter, if the resolution of the appeal was against the enrollee and the enrollee has not requested a state fair hearing or taken any further action; or
    3. A state fair hearing decision adverse to the enrollee has been issued;
   (b) Have an expedited review process for appeals if the MCO determines that allowing the enrollee a standard resolution could seriously jeopardize an enrollee’s life or health or ability to attain, maintain, or regain maximum function;
   (c) Resolve an expedited appeal within three (3) working days of receipt of the request; and
   (d) Extend the timeframe for an expedited appeal established
in paragraph (c) of this subsection by up to fourteen (14) calendar days if:

1. The enrollee requests the extension; or
2. a. The MCO demonstrates to the department that there is need for additional information; and
   b. The extension is in the enrollee’s interest.
(15) For an extension requested by an MCO, the MCO shall give the enrollee written notice of the reason for the extension.
(16) If an MCO denies a request for an expedited resolution of an appeal, it shall:
   (a) Transfer the appeal to the thirty (30) day timeframe for a standard resolution, in which the thirty (30) day period shall begin on the date the MCO received the original request for appeal;
   (b) Give prompt oral notice of the denial; and
   (c) Follow up with a written notice within two (2) calendar days of the denial;
(17) An MCO shall document in writing an oral request for an expedited resolution and shall maintain the documentation in the enrollee case file.
(18) An MCO shall:
   (a) Provide information specified in 42 C.F.R. 438.10(g)(1) about the grievance system to a service provider and a subcontractor at the time they enter into a contract;
   (b) Maintain a grievance or an appeal file in a secure and designated area;
   (c) Make a grievance or an appeal file accessible to the department or its designee upon request;
   (d) Retain a grievance or an appeal file for ten (10) years following a final decision by the MCO, the department, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later;
   (e) Have procedures for assuring that a grievance or an appeal file contains:
      1. Information to identify the grievance or appeal;
      2. The date a grievance or appeal was received;
      3. The nature of the grievance or appeal;
      4. A notice to the enrollee of receipt of the grievance or appeal;
      5. Correspondence between the MCO and the enrollee;
      6. The date the grievance or appeal is resolved;
      7. The decision made by the MCO of the grievance or appeal;
      8. The notice of a final decision to the enrollee; and
      9. Information pertaining to the grievance or appeal; and
   (f) Make available to an enrollee documentation regarding a grievance or an appeal.
(19) An MCO shall designate an individual to:
   (a) Execute the policies and procedures for resolution of a grievance or appeal;
   (b) Review patterns or trends in grievances or appeals; and
   (c) Initiate a corrective action, if needed.
(20) If an MCO takes adverse action at the conclusion of an internal appeal process, the MCO shall issue an adverse action letter to the enrollee that complies with KRS 13B.050(3)(d) and (e).
(21) The requirements and policies stated in this section of this administrative regulation regarding an MCO appeal shall apply to an MCO.
   (a) If a requirement or policy regarding an appeal or an MCO appeal stated in another Kentucky administrative regulation within Title 907 of the Kentucky Administrative Regulations contradicts a requirement or policy regarding an MCO appeal that is stated in this section of this administrative regulation, the requirement or policy stated in the other administrative regulation shall not apply to an MCO.

Section 5. Department’s State Fair Hearing for an Enrollee. (1) An enrollee shall have a right to a state fair hearing administered by the department in accordance with KRS Chapter 13B only after exhausting an MCO’s internal appeal process.
(2) The department shall provide an enrollee with a hearing process that shall adhere to 907 KAR 1:563; 42 C.F.R. 438, Subpart F; and 42 C.F.R. 431, Subpart E.
(3) An enrollee or authorized representative may request a state fair hearing by filing a written request with the department.
   (a) If an enrollee or authorized representative requests a hearing, the request shall:
      1. Be in writing and specify the reason for the request;
      2. Indicate the date of service or the type of service denied; and
      3. Be postmarked or filed within forty five (45) days from the date of the MCO adverse action letter issued at the conclusion of the MCO internal appeal process.
(4) A document supporting an MCO’s adverse action shall be:
   (a) Received by the department no later than five (5) days from the date a notice is sent to the MCO from the department that a request for a state fair hearing has been filed by an enrollee; and
   (b) Made available to an enrollee upon request by either the enrollee or the enrollee’s legal counsel.
(5) An automatic ruling shall be made by the department in favor of an enrollee if an MCO fails to:
   (a) Comply with the requirements of:
      1. Section 4 of this administrative regulation; and
      2. Subsection (4) of this section; or
   (b) Participate in and present evidence at the state fair hearing.

Section 6. Member Services. (1) An MCO shall have a member services function that includes a member call center and a behavioral health call center that shall:
   (a) Be staffed Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Time; and
   (b) Meet the call center standards, which shall:
      1. Be approved by the American Accreditation Health Care Commission or Utilization Review Accreditation Committee (URAC); and
      2. Include provisions addressing the call center abandonment rate, blockage rate, and average speed of answer.
(2)(a) An MCO shall provide access to medical advice to an enrollee through a toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week.
   (b) The call-in system shall be staffed by medical professionals to include:
      1. Physicians;
      2. Physician assistants;
      3. Licensed practical nurses; or
      4. Registered nurses.
(3) An MCO shall:
   (a) Provide foreign language interpreter services, free of charge, for an enrollee;
   (b) Respond to the special communication needs of the disabled, blind, deaf, or aged;
   (c) Facilitate direct access to a specialty physician for an enrollee:
      1. With a chronic or complex health condition;
      2. Who is aged, blind, deaf, or disabled; or
      3. Identified as having special healthcare need and requiring a course of treatment or regular healthcare monitoring;
   (d) Arrange for and assist with scheduling an EPSDT service in conformance with federal law governing EPSDT;
   (e) Provide an enrollee with information or refer the enrollee to a support service;
   (f) Facilitate direct access to a covered service in accordance with 907 KAR 17:020;
   (g) Facilitate access to a:
      1. Behavioral health service;
      2. Pharmaceutical service; or
      3. Service provided by a public health department, community mental health center, rural health clinic, federally qualified health center, the Commission for Children with Special Health Care Needs, or a charitable care provider;
   (h) Assist an enrollee in:
      1. Scheduling an appointment with a provider;
      2. Obtaining transportation for an emergency or non-emergency service;
      3. Completing a health risk assessment; or
      4. Accessing an MCO health education program;
   (i) Process, record, and track an enrollee grievance and appeal; or
   (j) Refer an enrollee to case management or disease management.

Section 7. Enrollee Selection of a Primary Care Provider. (1)
Except for an enrollee described in subsection (2) of this section, an MCO shall have a process for enrollee selection and assignment of a primary care provider.

(2) The following shall not be required to have, but may request, a primary care provider:

(a) A dual eligible;
(b) A child in foster care;
(c) A child under the age of eighteen (18) years who is disabled; or
(d) A pregnant woman who is presumptively eligible pursuant to 907 KAR 1:810.

(3)(a) For an enrollee who is not receiving supplemental security income benefits:

1. An MCO shall notify the enrollee within ten (10) days of notification of enrollment by the department of the procedure for choosing a primary care provider; and
2. If the enrollee does not choose a primary care provider, an MCO shall assign to the enrollee a primary care provider who:
   a. Has historically provided services to the enrollee; and
   b. Meets the requirements of subsection (6) of this section.
(b) If no primary care provider meets the requirements of paragraph (a) of this subsection, an MCO shall assign the enrollee to a primary care provider who:
   1. Thirty (30) miles or thirty (30) minutes from the enrollee's residence if the enrollee is in an urban area; or
   2. Forty-five (45) miles or forty-five (45) minutes from the enrollee's residence if the enrollee is in a rural area.

(4)(a) An enrollee who is receiving supplemental security income benefits and is not a dual eligible, an MCO shall notify the enrollee of the procedure for choosing a primary care provider.
(b) If an enrollee has not chosen a primary care provider within thirty (30) days, an MCO shall send a second notice to the enrollee.
(c) If an enrollee has not chosen a primary care provider within thirty (30) days of the second notice, the MCO shall send a third notice to the enrollee.
(d) If an enrollee has not chosen a primary care provider after the third notice, the MCO shall assign a primary care provider.

(e) Except for an enrollee who was previously enrolled with the MCO, an MCO shall not automatically assign a primary care provider within ninety (90) days of the enrollee's initial enrollment.

(5)(a) An enrollee shall be allowed to select from at least two (2) primary care providers within an MCO's provider network.
(b) At least one (1) of the two (2) primary care providers referenced in paragraph (a) of this subsection shall be a physician.

(6) A primary care provider shall:

(a) Be a licensed or certified health care practitioner who functions within the provider's scope of licensure or certification, including:
   1. A physician;
   2. An advanced practice registered nurse;
   3. A physician assistant; or
   4. A clinic, including a primary care center, federally qualified health center, or rural health clinic;
(b) Have admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges;
(c) Agree to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to enrollees; and
(d) For an enrollee who has a gynecological or obstetrical medical condition; or
   1. Being denied access to needed medical services.
   2. A PCP shall not be able to request the reassignment of an enrollee to a different PCP for the following reasons:
      (a) A change in the enrollee's health status or treatment needs;
      (b) An enrollee's utilization of health services;
      (c) An enrollee's diminished mental capacity; or
      (d) Disruptive behavior of an enrollee due to the enrollee's special health care needs unless the behavior impedes the PCP's ability to provide services to the enrollee or others.
   3. A PCP change request shall not be based on race, color, national origin, disability, age, or gender.
   (d) If an enrollee has no
   (5)(a) An enrollee shall be allowed to select from at least two (2) primary care providers within an MCO's provider network.
   (b) At least one (1) of the two (2) primary care providers referenced in paragraph (a) of this subsection shall be a physician.
   
1. In hardcopy in English, Spanish, and any other language spoken by at least five (5) percent of the potential enrollee or enrollee population; and
   2. On the MCO's Web site;
(b) Be written at no higher than a sixth grade reading comprehension level; and
(c) Include at a minimum the following information:
   1. The MCO's network of primary care providers, including the names, telephone numbers, and service site addresses of available primary care providers, and, if desired by the MCO, the names and contact information for other providers included in the MCO's network;
   2. The procedures for:
      a. Selecting a PCP and scheduling an initial health appointment;
      b. Obtaining:
         (i) Emergency or non-emergency care after hours;
         (ii) Transportation for emergency or non-emergency care;
         (iii) An EPSDT service;
         (iv) A covered service from an out-of-network provider; or
         (v) A long term care service;
   c. Notifying DCBS of a change in family size or address, a birth, or a death of an enrollee;
   d. Selecting or requesting to change a PCP;
   
1. Receiving poor quality care;
   2. Lacking access to providers qualified to treat the enrollee's medical condition; or
   3. Being denied access to needed medical services.
   8. A PCP shall not be able to request the reassignment of an enrollee to a different PCP for the following reasons:
      (a) A change in the enrollee's health status or treatment needs;
      (b) An enrollee's utilization of health services;
      (c) An enrollee's diminished mental capacity; or
      (d) Disruptive behavior of an enrollee due to the enrollee's special health care needs unless the behavior impedes the PCP's ability to provide services to the enrollee or others.
   9. A PCP change request shall not be based on race, color, national origin, disability, age, or gender.
   (10) An MCO shall have the authority to approve or deny a primary care provider change.
   
1. A family planning service in accordance with 42 C.F.R. 431.51;
2. An emergency service in accordance with 42 C.F.R. 438.114;
3. A poststabilization service in accordance with 42 C.F.R. 438.114 and 42 C.F.R. 422.113(c); or
(d) An out-of-network service that an MCO is unable to provide within its network to meet the medical need of the enrollee in accordance with 42 C.F.R. 438.206(b)(4) subject to any prior authorization requirements of the MCO.

(12) An MCO shall:
   (a) Notify an enrollee within:
      1. Thirty (30) days of the effective date of a voluntary termination of the enrollee's primary care provider; or
      2. Fifteen (15) days of an involuntary termination of the enrollee's primary care provider; and
   (b) Assist the enrollee in selecting a new primary care provider.

Section 8. Member Handbook. (1) An MCO shall:
   (a) Send a member handbook to an enrollee, by a method that shall not take more than three (3) days to reach the enrollee, within five (5) business days of enrollment;
   (b) Review the member handbook at least annually;
   (c) Communicate a change to the member handbook to an enrollee in writing; and
   (d) Add a revision date to the member handbook after revising the member handbook.

(2) A member handbook shall:
   (a) Be available:
      1. In hardcopy in English, Spanish, and any other language spoken by at least five (5) percent of the potential enrollee or enrollee population; and
      2. On the MCO's Web site;
   (b) Be written at no higher than a sixth grade reading comprehension level; and
   
1. Title, address, and
telephone number of the person responsible for processing and resolving a grievance or appeal;
3. The name of the MCO, address, and telephone number from which it conducts its business;
4. The MCO’s:
   a. Business hours; and
   b. Member service and toll-free medical call-in telephone numbers;
5. Covered services, an explanation of any service limitation or exclusion from coverage, and a notice stating that the MCO shall be liable only for those services authorized by the MCO, except for the services excluded in Section 7(11) of this administrative regulation;
6. Member rights and responsibilities;
7. For a life-threatening situation, instructions to use the emergency medical services available or to activate emergency medical services by dialing 911;
8. Information on:
   a. The availability of maternity and family planning services, and for the prevention and treatment of sexually transmitted diseases;
   b. Accessing the services referenced in clause a. of this subparagraph;
   c. Accessing care before a primary care provider is assigned or chosen;
   d. The Cabinet for Health and Family Services’ independent ombudsman program; and
   e. The availability of, and procedures for, obtaining:
      (i) A behavioral health or substance abuse service;
      (ii) A health education service; and
      (iii) Care coordination, case management, and disease management services;
   f. Direct access services that may be accessed without a referral; and
   g. The acknowledgement referenced in subparagraph 1 of this subsection in accordance with KRS 194A.060, KRS 214.185, KRS 434.840 to 434.860, and 42 C.F.R. 431 Subpart F, 431.300 to 431.307;
10. An enrollee’s right to obtain a second opinion and information on obtaining a second opinion; and
11. Meet the information requirements established in Section 11 of this administrative regulation.
(3) Changes to the member handbook shall be approved by the department prior to the publication of the handbook.

Section 9. Member Education and Outreach. (1) An MCO shall:
(a) Have an enrollee and community education and outreach program throughout the MCO’s service area;
(b) Submit an annual outreach plan to the department for approval;
(c) Assess the homeless population within its service area by implementing and maintaining an outreach plan for homeless individuals, including victims of domestic violence; and
(d) Not differentiate between a service provided to an enrollee who is homeless and an enrollee who is not homeless.
(2) An MCO’s outreach plan shall include:
(a) Utilizing existing community resources including shelters and clinics; and
(b) Face-to-face encounters.

Section 10. Enrollee Non-Liability for Payment. (1) Except as specified in 907 KAR 17:030, an enrollee shall not be required to pay for a medically necessary covered service provided by the enrollee’s MCO.
(2) An MCO shall not impose cost sharing on an enrollee greater than the limits established by the department in 907 KAR 1:604.

Section 11. Provision of Information Requirements. (1) An MCO shall:
(a) Comply with the requirements established in 42 U.S.C. 1396u-2(a)(5) and 42 C.F.R. 438.10; and
(b) Provide translation services to an enrollee on site or via telephone.
(2) Written material provided by an MCO to an enrollee or potential enrollee shall:
(a) Be written at a sixth grade reading comprehension level; and
(b) Be published in at least a fourteen (14) point font;
(c) Comply with the requirements established in 42 U.S.C. Chapter 126, the Americans with Disabilities Act;
(d) Be updated as necessary to maintain accuracy;
(e) Be available in Braille or in an audio format for an individual who is partially blind or blind; and
(f) Be provided and printed in each language spoken by five (5) percent or more of the enrollees in each county.
(3)(a) All written material intended for an enrollee, unless unique to an individual enrollee or exempted by the department, shall be submitted to the department for review and approval prior to publication or distribution to the enrollee.
(b) Written material submitted to the department for review by an MCO shall be considered approved by the department if the department does not object or notify an MCO within:
1. Thirty (30) days regarding a standard submission; or
2. Five (5) days regarding an expedited submission.
(c)1. Written material submitted to the department for review and approval shall be considered received for review beginning with the date that the commissioner or a deputy commissioner of the department acknowledges, to the MCO, receipt of the submission.
2. The acknowledgement referenced in subparagraph 1 of this paragraph may be demonstrated by evidence of a return receipt if sent via U.S. Mail, a read receipt if sent via e-mail, or the signature of a Cabinet for Health and Family Services employee taking receipt of the submission in the case of hand-delivery, including overnight mail or courier delivery.

Section 12. Confidentiality of Medical Information. (1) An MCO shall:
(a) Maintain confidentiality of all enrollee eligibility information and medical records;
(b) Prevent unauthorized disclosure of the information referenced in this subsection in accordance with KRS 194A.060, KRS 214.185, KRS 434.840 to 434.860, and 42 C.F.R. 431 Subpart F, 431.300 to 431.307;
(c) Have written policies and procedures for maintaining the confidentiality of enrollee records;
(d) Comply with 42 U.S.C. 1320d-2, the Health Insurance Portability and Accountability Act, and 45 C.F.R. Parts 160 and 164;
(e) On behalf of its employees and agents:
   1. Sign a confidentiality agreement attesting that it will comply with the confidentiality requirements established in this section; and
   2. Submit the confidentiality agreement referenced in subparagraph 1 of this paragraph to the department;
(f) Limit access to medical information to a person or agency which requires the information in order to perform a duty related to the department’s administration of the Medicaid program, including the department, the United States Department of Health and Human Services, the United States Attorney General, the CHFS OIG, the Kentucky Attorney General, or other agency required by the department; and
(g) Submit a request for disclosure of information referenced in this subsection which has been received by the MCO to the department within twenty-four (24) hours.
(2) Information referenced in subsection (1) of this section shall not be disclosed by an MCO pursuant to the request without prior written authorization from the department.

Section 13. Americans with Disabilities Act and Cabinet Ombudsman. (1) An MCO shall:
(a) Require by contract with its network providers and subcontractors that a service location meets:
1. The requirements established in 42 U.S.C. Chapter 126, the Americans with Disabilities Act; and
2. All local requirements which apply to health facilities pertaining to adequate space, supplies, sanitation, and fire and safety procedures;
(b) Fully cooperate with the Cabinet for Health and Family Services independent ombudsman; and
(c) Provide immediate access to the Cabinet for Health and Family Services independent ombudsman, to an enrollee’s records if the enrollee has given consent.
Section 14. Marketing. (1) An MCO shall:
(a) Comply with the requirements established in 42 C.F.R. 438.104 regarding marketing activities;
(b) Have a system of control over the content, form, and method of dissemination of its marketing and information materials;
(c) Submit a marketing plan and marketing materials to the department for written approval prior to implementation or distribution;
(d) If conducting mass media marketing, direct the marketing activities to enrollees in the entire service area pursuant to the marketing plan;
(e) Not conduct face-to-face marketing;
(f) Not use fraudulent, misleading, or misrepresentative information in its marketing materials;
(g) Not offer a personal financial gain to a:
1. Potential enrollee as an inducement to select a particular provider or use a product; or
2. Person for the purpose of soliciting, referring, or otherwise facilitating the enrollment of an enrollee;
(h) Not conduct:
1. Direct telephone marketing to enrollees or potential enrollees who do not reside in the MCO service area; or
2. Direct or indirect door-to-door, telephone, or other cold-call marketing activity; and
(i) Not include in its marketing materials an assertion or statement that the Centers for Medicare and Medicaid Services (CMS), the federal government, the Commonwealth, or another entity endorses the MCO.
(2) An MCO’s marketing material shall meet the information requirements established in Section 11 of this administrative regulation.

Section 15. Legal Guardians. (1) A parent, custodial parent, person exercising custodial control or supervision, or an agency with a legal responsibility for a child by virtue of a voluntary commitment or of an emergency or temporary custody order shall be authorized to act on behalf of an enrollee who is under the age of eighteen (18) years, a potential enrollee, or a former enrollee for the purpose of:
(a) Selecting a primary care provider;
(b) Filing a grievance or appeal; or
(c) Taking an action on behalf of the child regarding an interaction with an MCO.
(2)(a) A legal guardian who has been appointed pursuant to KRS 387.500 to 387.800 shall be allowed to act on behalf of an enrollee who is a ward of the Commonwealth.
(b) A person authorized to make a health care decision pursuant to KRS 311.621 to 311.643 shall be allowed to act on behalf of an enrollee, potential enrollee, or former enrollee.
(c) An enrollee shall have the right to:
1. Represent the enrollee; or
2. Use legal counsel, a relative, a friend, or other spokesperson.

Section 16. Enrollee Surveys. (1) An MCO shall:
(a) Conduct an annual survey of enrollee satisfaction of the quality and accessibility to a service provided by an MCO;
(b) Satisfy a member satisfaction survey requirement by participating in the Agency for Health Research and Quality’s current Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) for Medicaid Adults and Children, which shall be administered by an NCQA-certified survey vendor;
(c) Provide a copy of the current CAHPS survey referenced in paragraph (b) of this subsection to the department;
(d) Annually assess the need for conducting other surveys to support quality and improvement initiatives;
(e) Submit to the department for approval the survey tool used to conduct the survey referenced in paragraph (a) of this subsection; and
(f) Provide to the department:
1. A copy of the results of the enrollee surveys referenced in paragraph (a) of this subsection;
2. A description of a methodology to be used to conduct surveys;
3. The number and percentage of enrollees surveyed;
4. Enrollee survey response rates;
5. Enrollee survey findings; and
6. Interventions conducted or planned by the MCO related to activities in this section.
(2) The department shall:
(a) Approve enrollee survey instruments prior to implementation; and
(b) Approve or disapprove an MCO’s enrollee survey tool within fifteen (15) days of receipt of the survey tool.
(3) If an MCO conducts a survey that targets a sub-population’s perspective or experience with access, treatment, or services, the MCO shall comply with the requirements established in subsection (1)(e) and (f) of this section.

Section 17. Enrollees with Special Health Care Needs. (1) In accordance with 42 C.F.R. 438.208:
(a) The following shall be considered an individual with a special health care need:
1. A child in or receiving foster care or adoption assistance;
2. A homeless individual;
3. An individual with a chronic physical or behavioral illness;
4. A blind or disabled child;
5. An individual who is eligible for SSI benefits; or
6. An adult who is a ward of the Commonwealth in accordance with 910 KAR Chapter 2; and
(b) An MCO shall:
1. Have a process to target enrollees for the purpose of screening and identifying those with special health care needs;
2. Assess each enrollee identified by the department as having a special health care need to determine if the enrollee needs case management or regular care monitoring;
3. Include the use of appropriate health care professionals to perform an assessment; and
4. Have a treatment plan for an enrollee with a special health care need who has been determined, through an assessment, to need a course of treatment or regular care monitoring.
(2) A treatment plan referenced in subsection (1)(b)(4) of this section shall be developed:
(a) With participation from the enrollee or the enrollee’s legal guardian as referenced in Section 15 of this administrative regulation; and
(b) By the enrollee’s primary care provider, if the enrollee has a primary care provider.
(3) An MCO shall:
(a)1. Develop materials specific to the needs of an enrollee with a special health care need; and
2. Provide the materials referenced in subparagraph 1. of this paragraph to the enrollee, caregiver, parent, or legal guardian;
(b) Have a mechanism to allow an enrollee identified as having a special health care need to directly access a specialist, as appropriate, for the enrollee’s condition and identified need; and
(c) Be responsible for the ongoing care coordination for an enrollee with a special health care need.
(4) The information referenced in subsection (3)(a) of this section shall include health educational material to assist the enrollee with a special health care need or the enrollee’s caregiver, parent, or legal guardian in understanding the enrollee’s special need.
(5)(a) An enrollee who is a child in foster care or receiving adoption assistance shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DCBS prior to being enrolled with the MCO.
(b) The service plan referenced in paragraph (a) of this subsection shall be used by DCBS and the MCO to determine the enrollee’s medical needs and identify the need for case management.
(c) The MCO shall be available to meet with DCBS at least once a month to discuss the health care needs of the child as identified in the service plan.
(d) If a service plan identifies the need for case management
or DCBS requests case management for an enrollee, the foster parent of the child or DCBS shall work with the MCO to develop a case management plan of care.

(e) The MCO shall consult with DCBS prior to developing or modifying a case management plan of care.

(6)(a) An enrollee who is a ward of the Commonwealth shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DAIL prior to being enrolled with the MCO.

(b) If the service plan referenced in paragraph (a) of this subsection identifies the need for case management, the MCO shall work with DAIL or the enrollee to develop a case management plan of care.

Section 18. Second Opinion. An enrollee shall have the right to a second opinion within the MCO’s provider network for a surgical procedure or diagnosis and treatment of a complex or chronic condition.

Section 19. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies or does not provide federal financial participation for the policy; or

(2) Disapproves the policy.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation will be held on February 21, 2013 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intention to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email jill.brown@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen
(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) requirements and policies relating to providers. Previously, those policies were contained in one (1) administrative regulation - 907 KAR 17:005 – which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3)). Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is using the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. Though this is a new administrative regulation, it does contain some amended policies. The amendments include eliminating cost (MCO capitation rate for the individual) as a factor in the Department for Medicaid Services’ (DMS’s) algorithm used to assign individuals to a managed care organization (MCO); removing the requirement that an enrollee’s annual open enrollment opportunity (with an MCO) occurs at the enrollee’s annual time to recertify Medicaid eligibility or during the birth month for enrollees who receive supplemental security income (SSI) benefits; establishing or enhancing Medicaid managed care organization requirements and policies relating to individuals with disabilities served by the Department for Commonwealth Services and Family Investment Services (DCBS); waiving the requirements that enrollees exhaust the MCO’s appeal process first; clarifying that certain individuals who are not required to have a primary care provider may choose to have one; and clarifying that access to out-of-network services are subject to prior authorization by an MCO.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to individuals enrolled with a managed care organization. Eliminating cost (MCO capitation rate for the individual) as a factor in the algorithm used to assign enrollees to MCOs is necessary to prevent excessive assignments of enrollees to the MCO with the lowest capitation rate; eliminating the statement that enrollee’s annual open enrollment period occurs during their annual Medicaid eligibility recertification period or (for SSI recipients) during their birth month, is necessary as DMS is adopting a mass annual open enrollment period annually; establishing that DMS will reimburse for services to retro-eligible SSI benefit recipients is necessary as SSI retro eligibility can extend back to long periods of time and typically the individuals have substantial medical claims during the retro eligibility period and the MCOs obviously had no opportunity to manage the care (a non-SSI retro eligibility period can only extend back three months); requiring enrollees to exhaust the MCO appeal process before seeking a state fair hearing is necessary to eliminate duplication between MCOs and DMS as some individuals initiated both appeal processes concurrently which resulted in DMS and the MCO both spending time and efforts attempting to resolve the given matter only to discover that the other party had resolved the matter; stating that certain individuals who are not required to have a primary care provider but may have one is necessary to clarify existing policy; stating that out-of-network services (other than those exempt from prior authorization) are subject to MCO prior authorization is necessary to clarify current policy.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to individuals enrolled with a managed care organization. The amended policies conform to the content of the authorizing statutes by clarifying or enhancing Medicaid managed care organization policies and requirements based on a year of experience and analysis.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the
authorizing statutes by clarifying or enhancing Medicaid managed care organization policies and requirements based on a year of experience and analysis.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.
(e) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.
(d) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.
(b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year are $3,198,870,633.

(5) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment:
(a) No increase in fees is necessary.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment:
(a) No increase in fees is necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is neither applied nor necessary as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438. This administrative regulation established MCO requirements and policies regarding individuals enrolled in a managed care organization. Those requirements are established in 42 C.F.R. 438.10, 42 C.F.R. 438.52, 42 C.F.R. 438.56, 42 C.F.R. 438.62, 42 C.F.R. 438.66, 42 C.F.R. 438.100-108, 42 C.F.R. 438.224-228 and 42 C.F.R. 438.400 – 408.

2. State compliance standards. KRS 205.520(3) states, “Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.” Part I, Section G. Budget Unit 3. a.(b)(17) of House Bill 265 of the 2012 Session of the General Assembly states: “(17) Appeals: An appeal from denial of a service or services provided by a Medicaid managed care organization for medical necessity, or denial, limitation, or termination of a health care service in a case involving a medical or surgical specialty or subspecialty, shall, upon request of the recipient, authorized person, or provider, include a review by a board-eligible or board-certified physician in the appropriate specialty or subspecialty area; except in the case of a health care service rendered by a chiropractor or optometrist, in which case, the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky as specified in KRS 304.17A-607(1)(b). The physician reviewer shall not have participated in the initial review and denial of service and shall not be the provider of service or services under consideration in the appeal.”

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation establishes MCO requirements regarding individuals enrolled with a managed care organization. Those requirements include: DMS must approve all managed care providers to be distributed by anyone intended to affect a Medicaid recipient’s choice of managed care plan; all written material relating to any plan must be designed to be easily understood; alternative formats must be available to meet the needs of individuals with visual or other disabilities or limited reading proficiency; written material must be available in every prevalent non-English language in the service area, and oral translation must be available in any non-English language; information required to make a choice about enrollment must be provided in time to help the beneficiary choose; MCOs must make detailed disclosures to enrollees on the provider network and the terms of the plan; all enrollment notices and informational and instructional materials must be in an easily understood form; information concerning providers, enrollee rights and responsibilities, and appeal procedures, and information on covered items and services must be provided; each potential enrollee must be given information and evidence that facts and features of managed care generally, the populations who are required, permitted or excluded from enrollment in a managed care plan; DMS or the MCOs must disclose at least:

any Medicaid services that are excluded from coverage;

cost sharing requirements; the service area;

the names, locations and contact information for participating providers, any non-English languages spoken and whether they are accepting new Medicaid patients;

all services provided, the procedures for obtaining services, and the transportation provided. If the managed care entity does not provide counseling or referral for any services on moral or religious grounds, the state must provide the information necessary for enrollees to obtain those services;

DMS must assure that all enrollees in Medicaid managed care are notified annually of their right to disenroll; all enrollees have a right to be informed of the same information available to potential enrollees (in greater detail), the amount, duration and scope of services available, their rights with respect to emergency care, the grievance and appeal procedure, the termination of a participating provider and of significant changes in the plan; an MCO must give Medicaid enrollees the right to appeal adverse decisions which include:

1. the denial or limited authorization of a requested service or level of service;

2. the suspension, termination or reduction of a previously authorized service;
3. The failure to provide services in a timely manner, as defined by the State;
4. the denial, in whole or in part, of payment for a service;
5. the failure of an MCO or PIPH to act within the timeframes provided for grievances and appeals; and
6. for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

MCOs must have a system which includes an appeal process and access to a state fair hearing process; states, may require an exhaustion of the appeals process before requesting a state fair hearing; an oral request for an appeal must be followed by a signed, written request except when an expedited appeal is requested; MCOs and states must give written notice of an action within specified time limits; the written notice must meet the clarity requirements of 42 C.F.R. 438.10; the notice must state the action taken, give the reason(s) for an action and the appeal process; DMS must provide a method to file an appeal, including the procedures for expedited resolution; Notification of decisions to terminate, suspend or reduce services must be given within the time limits required for Medicaid services under 42 C.F.R. Part 431; any appeal of a denial based on medical necessity or of any other action involving clinical issues must be decided by health care professionals who have appropriate clinical expertise in treating the enrollee's condition; and all appeals must be decided by individuals who were not involved in the decision or in any previous level of review.

DMS must give individuals a choice of at least two managed care entities or managers. In rural areas, eligible individuals must be permitted a choice of at least two physicians or case managers, to the extent that at least two such individuals are available. Enrollees may terminate or change plans at any time for cause, and may terminate or change plans without cause during the 90-day period beginning on the date on which the individual receives notice of enrollment and at least once annually thereafter; DMS must establish a notice of termination requirements as well as a method for establishing enrollment priorities in the event a managed care entity does not have sufficient capacity to enroll all persons seeking enrollment; MCOs must provide that eligible enrollees may not be held liable for: (1) the debts of the organization in the event of its insolvency; (2) services provided to the enrollee if the organization or healthcare provider fails to receive payment from the state for such services; or (3) payments to a provider in excess of the amount that would be owed by the enrollee if the organization had directly provided the services; providers and subcontractors may charge enrollees only for any unpaid cost-sharing amounts that the state has lawfully imposed, not for differing between the rate the provider agreed to accept from the MCO and the provider's usual fee; all marketing materials must be approved by the state and cannot contain false or materially misleading information; an MCO must distribute marketing materials to its entire service area, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance, and must comply with procedures and conditions prescribed by the Health and Human Services (HHS) Secretary to ensure that a potential enrollee is provided accurate oral and written information sufficient to make an informed enrollment decision; and an MCO may not, directly or indirectly, conduct door-to-door, telephone, or other "cold-call" marketing.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care but does not impose additional or stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A managed care method of administering the program is being implemented but stricter requirements are not imposed. A managed care program is not federally mandated for Medicaid programs.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT:
1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None. (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

4. A local health department; and
5. A community mental health center;
6. A rural health clinic;
7. A health department, and primary care center administrators by this administrative regulation. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the managed care organization requirements and policies relating to providers.

Section 1. Provider Network. (1) An MCO shall: (a) Enroll providers of sufficient types, numbers, and specialties to its network to satisfy the:
1. Access and capacity requirements established in Section 2 of this administrative regulation; and
2. Quality requirements established in 907 KAR 17:025;
(b) Attempt to enroll the following providers in its network:
1. A teaching hospital;
2. A rural health clinic;
3. The Kentucky Commission for Children with Special Health Care Needs;
4. A local health department; and
5. A community mental health center;
services to Medicaid recipients;
(d) Have at least one (1) FQHC in a region where the MCO operates in accordance with 907 KAR 17:020, if there is an FQHC that is licensed to provide services in the region; and
(e) Exclude, terminate, or suspend from its network a provider or subcontractor who engages in an activity that results in suspension, termination, or exclusion from the Medicare or a Medicaid program.

(2) The length of an exclusion, termination, or suspension referenced in subsection (1)(e) of this section shall equal the length of the exclusion, termination, or suspension imposed by the Medicare or a Medicaid program.

(3) If an MCO is unable to enroll a provider specified in subsection (1)(b) or (c) of this section, the MCO shall submit to the department for approval, documentation which supports the MCO’s conclusion that adequate services and service sites as required in Section 2 of this administrative regulation shall be provided without enrolling the specified provider.

If an MCO or the department determines that the MCO’s provider network is inadequate to comply with the access standards established in Section 2 of this administrative regulation for ninety-five (95) percent of the MCO’s enrollees, the MCO shall:
(a) Notify the department; and
(b) Submit a corrective action plan to the department.

(5) A corrective action plan referenced in subsection (4)(b) of this section shall:
(a) Describe the deficiency in detail; and
(b) Identify a specific action to be taken by the MCO to correct the deficiency, including a time frame.

Section 2. Provider Access Requirements. (1) The access standards requirements established in 42 C.F.R. 438.206 through 438.210 shall apply to an MCO.

(2) An MCO shall make available and accessible to an enrollee:
(a) Facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section;
(b) Emergency medical services twenty-four (24) hours a day, seven (7) days a week; and
(c) Urgent care services within 48 hours of request.

(3)(a) An MCO’s primary care provider delivery site shall be within:
1. Thirty (30) miles or thirty (30) minutes from an enrollee’s residence in an urban area; or
2. Forty-five (45) miles or forty-five (45) minutes from an enrollee’s residence in a non-urban area.

(b) An MCO’s primary care provider shall not have an enrollee to primary care provider ratio greater than 1,500:1.

(c) An appointment wait time at an MCO’s primary care delivery site shall not exceed:
1. Thirty (30) days from the date of an enrollee’s request for a routine or preventive service; or
2. Forty-eight (48) hours from an enrollee’s request for urgent care.

(4)(a) An appointment wait time for a specialist, except for a specialist providing a behavioral health service as provided in paragraph (b) of this subsection, shall not exceed:
1. Thirty (30) days from the referral for routine care; or
2. Forty-eight (48) hours from the referral for urgent care.

(b)1. A behavioral health service requiring crisis stabilization shall be provided within twenty-four (24) hours of the referral.
2. Behavioral health urgent care shall be provided within forty-eight (48) hours of the referral.
3. A behavioral health service appointment following a discharge from an acute psychiatric hospital shall occur within fourteen (14) days of discharge.
4. A behavioral health service appointment not included in subparagraph 1. 2, or 3 of this paragraph shall occur within sixty (60) days of the referral.

(5) An MCO shall have:
(a) Specialists available for the subpopulations designated in 907 KAR 17:010, Section 16; and
(b) Sufficient pediatric specialists to meet the needs of enrollees who are less than twenty-one (21) years of age.

(6) An emergency service shall be provided at a health care facility most suitable for the type of injury, illness, or condition, whether or not the facility is in the MCO network.

(7) A hospital shall be within:
(a) Thirty (30) miles or thirty (30) minutes of an enrollee’s residence in an urban area; or
(b) Sixty (60) miles or sixty (60) minutes of an enrollee’s residence in a non-urban area.

(8) A behavioral or physical rehabilitation service shall be within sixty (60) miles or sixty (60) minutes of an enrollee’s residence.

(9)(a) A dental service shall be within sixty (60) miles or sixty (60) minutes of an enrollee’s residence.
(b) A dental appointment wait time shall not exceed:
1. Three (3) weeks for a regular appointment; or
2. Forty-eight (48) hours for urgent care.

(10)(a) A general vision, laboratory, or radiological service shall be within sixty (60) miles or sixty (60) minutes of an enrollee’s residence.
(b) A general vision, laboratory, or radiological appointment wait time shall not exceed:
1. Three (3) weeks for a regular appointment; or
2. Forty-eight (48) hours for urgent care.

Section 3. MCO Provider Enrollment. (1) A provider enrolled with an MCO shall:
(a) Be credentialed by the MCO in accordance with the standards established in Section 4 of this administrative regulation; and
(b) Be eligible to enroll with the Kentucky Medicaid Program in accordance with 907 KAR 1:672.

(2) An MCO shall:
(a) Not enroll a provider in its network if:
1. The provider has an active sanction imposed by the Centers for Medicare and Medicaid Services or a state Medicaid agency; or
2. Provide delivery to the enrollee’s residence.

(12)(a) Prior authorization shall not be required for a physical emergency service or a behavioral health emergency service.
(b) In order to be covered, an emergency service shall be:
1. Medically necessary;
2. Authorized after being provided if the service was not prior authorized; and
3. Covered in accordance with 907 KAR 17:020.

Section 4. Provider Credentialing and Recredentialing. (1) An MCO shall:
(a) Have policies and procedures that comply with 907 KAR 1:672; KRS 205.560; and 42 C.F.R. 455 Subpart E, 455.400 to 455.470, regarding the credentialing and recredentialing of a provider;
(b) Have a process for verifying a provider's credentials and malpractice insurance that shall include:

1. Written policies and procedures for credentialing and recredentialing of a provider;
2. A governing body, or a group or individual to whom the governing body has formally delegated the credentialing function; and
3. A review of the credentialing policies and procedures by the governing body or its delegate;

(c) Have a credentialing committee that makes recommendations regarding credentialing;

(d) If a provider requires a review by the credentialing committee, based on the MCO's quality criteria, notify the department of the facts and outcomes of the review;

(e) Have written policies and procedures for:
   1. Excluding, terminating, or suspending a provider; and
   2. Reporting a quality deficiency that results in an exclusion, suspension, or termination of a provider;

(f) Document its monitoring of a provider;

(g) Verify a provider's qualifications through a primary source that includes:
   1. A current valid license or certificate to practice in the Commonwealth of Kentucky;
   2. A Drug Enforcement Administration certificate and number, if applicable;
   3. If a provider is not board certified, proof of graduation from a medical school and completion of a residency program;
   4. Proof of completion of an accredited nursing, dental, physician assistant, or vision program, if applicable;
   5. If a provider states on an application that the provider is board certified in a specialty, a professional board certification;
   6. A previous five (5) year work history;
   7. A professional liability claims history;
   8. If a provider requires access to a hospital to practice, proof that the provider has clinical privileges and is in good standing at the hospital designated by the provider as the primary admitting hospital;
   9. Malpractice insurance;
   10. Documentation, if applicable, of a:
      a. Revocation, suspension, or probation of a state license or Drug Enforcement Agency certificate and number;
      b. Sanction or penalty imposed by the United States Department of Health and Human Services or a state Medicaid agency;
      c. Professional association; and
      d. Censure by a state or county professional association; and
   11. The most recent provider information available from the National Practitioner Data Bank;

(h) Obtain access to the National Practitioner Data Bank as part of its credentialing process;

(i) Have:
   1. A process to recredential a provider at least once every three (3) years that shall be in accordance with subsection (3) of this section; and
   2. Procedures for monitoring a provider sanction, a complaint, or a quality issue between a recredentialing cycle;

(j) Have or obtain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line within four (4) years of implementation of this administrative regulation; and

(k) Continuously maintain NCQA accreditation for its Medicaid product line after obtaining the accreditation.

(2) If an MCO subcontracts a credentialing or recredentialing function, the MCO and the subcontractor shall have written policies and procedures for credentialing and recredentialing.

(3) A provider shall complete a credentialing application, in accordance with 907 KAR 1:672, that includes a statement by the provider regarding:

(a) The provider's ability to perform essential functions of a position, with or without accommodation;
(b) The provider's lack of current illegal drug use;
(c) The provider's history of a:
   1. Loss of license or a felony conviction;
   2. Loss or limitation of a privilege; or
   3. Disciplinary action;
(d) A sanction, suspension, or termination by the United States Department of Health and Human Services or a state Medicaid agency;
(e) Clinical privileges and standing at a hospital designated as the primary admitting hospital of the provider;
(f) Malpractice insurance maintained by the provider; and
(g) The correctness and completeness of the application.

(4) The department shall be responsible for credentialing and recredentialing a hospital-based provider.

Section 5. Provider Services. (1) An MCO shall have a provider services function responsible for:

(a) Enrolling, credentialing, recredentialing, and evaluating a provider;
(b) Assisting a provider with an inquiry regarding enrollee status, prior authorization, referral, claim submission, or payment;
(c) Informing a provider of the provider's rights and responsibilities;
(d) Handling, recording, and tracking a provider grievance and appeal;

(e) Developing, distributing, and maintaining a provider manual;

(f) Provider orientation and training, including:
   1. Medicaid covered services;
   2. EPSDT coverage;
   3. Medicaid policies and procedures;
   4. MCO policies and procedures; and
   5. Fraud, waste, and abuse;

(g) Assisting in coordinating care for a child or adult with a complex or chronic condition;

(h) Assisting a provider with enrolling in the Vaccines for Children Program in accordance with 907 KAR 1:680; and

(i) Providing technical support to a provider regarding the provision of a service.

(2) An MCO's provider services staff shall:

(a) Be available at a minimum Monday through Friday from 8:00 a.m. to 6:00 p.m. Eastern Time; and
(b) Operate a provider call center.

Section 6. Provider Manual. (1) An MCO shall provide a provider manual to a provider within five (5) working days of enrollment with the MCO.

(2) Prior to distributing a provider manual or update to a provider manual, an MCO shall procure the department's approval of the provider manual or provider manual update.

(3) The provider manual shall be available in hard copy and on the MCO's Web site.

Section 7. Provider Orientation and Education. An MCO shall:

(1) Conduct an initial orientation for a provider within thirty (30) days of enrollment with the MCO to include:
   (a) Medicaid coverage policies and procedures;
   (b) Reporting fraud and abuse;
   (c) Medicaid eligibility groups;
   (d) The standards for preventive health services;
   (e) The special needs of enrollees;
   (f) Advance medical directives;
   (g) EPSDT services;
   (h) Claims submission;
   (i) Care management or disease management programs available to enrollees;
   (j) Cultural sensitivity;
   (k) The needs of enrollees with mental, developmental, or physical disabilities;
   (l) The reporting of communicable diseases;
   (m) The MCO's QAPI program as referenced in 907 KAR 17:025;
   (n) Medical records;
   (o) The external quality review organization; and
   (p) The rights and responsibilities of enrollees and providers; and

(2) Ensure that a provider:
   (a) Is informed of an update on a federal, state, or contractual requirement;
   (b) Receives education on a finding from its QAPI program if deemed necessary by the MCO or department; and
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(c) Makes available to the department training attendance rosters that shall be dated and signed by the attendees.

Section 8. Primary Care Provider Responsibilities. (1) A PCP shall:
   (a) Maintain:
       1. Continuity of an enrollee’s health care;
       2. A current medical record for an enrollee in accordance with 907 KAR 17:010; and
       3. Formalized relationships with other PCPs to refer enrollees for after-hours care, during certain days, for certain services, or other reasons to extend their practice;
   (b) Refer an enrollee for specialty care or other medically necessary services, both in and out of network, if the services are not available within the MCO’s network;
   (c) Discuss advance medical directives with an enrollee;
   (d) Provide primary and preventive care, including EPSDT services;
   (e) Refer an enrollee for a behavioral health service if clinically indicated; and
   (f) Have an after-hours phone arrangement that ensures that a PCP or a designated medical practitioner returns the call within thirty (30) minutes.
   (2) An MCO shall monitor a PCP to ensure compliance with the requirements established in this section.

Section 9. Provider Discrimination. An MCO shall:
   (1) Comply with the anti-discrimination requirements established in:
       (a) 42 U.S.C. 1396u-2(b)(7);
       (b) 42 C.F.R. 438.12; and
       (c) KRS 304.17A-270; and
   (2) Provide written notice to a provider denied participation in the MCO’s network stating the reason for the denial.

Section 10. Release for Ethical Reasons. An MCO shall:
   (1) Not require a provider to perform a treatment or procedure that is contrary to the provider’s conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. 438.102;
   (2) Not prohibit or restrict a provider from advising an enrollee about health status, medical care, or a treatment:
       (a) Whether or not coverage is provided by the MCO; and
       (b) If the provider is acting within the lawful scope of practice; and
   (3) Have a referral process in place if a provider declines to perform a service because of an ethical reason.

Section 11. Provider Grievances and Appeals. (1) An MCO shall have written policies and procedures for the filing of a provider grievance or appeal.
   (2) A provider shall have the right to file:
       (a) A grievance with an MCO; or
       (b) An appeal with an MCO regarding:
           1. A provider payment issue; or
           2. A contractual issue.
   (3)(a) A provider grievance or appeal shall be resolved within thirty (30) calendar days.
       (b) If a grievance or appeal is not resolved within thirty (30) days, an MCO shall request a fourteen (14) day extension from the provider.
       2. The provider shall approve the extension request from the MCO;
       (c) If a provider requests an extension, the MCO shall approve the extension.

Section 12. Medical Records. (1) An MCO shall:
   (a) Require a provider to maintain an enrollee medical record on paper or in an electronic format; and
   (b) Have a process to systematically review provider medical records to ensure compliance with the medical records standards established in this section.
   (2) An enrollee medical record shall:
       (a) Be legible, current, detailed, organized, and signed by the service provider; and
       (b)1. Be kept for at least five (5) years from the date of service unless a federal statute or regulation requires a longer retention period; and
          2. If a federal statute or regulation requires a retention period longer than five (5) years, be kept for at least as long as the federally required retention period;
   (c) Include the following minimal detail for an individual clinical encounter:
       1. The history and physical examination for the presenting complaint;
       2. A psychological or social factor affecting the patient’s physical or behavioral health;
       3. An unresolved problem, referral, or result from a diagnostic test; and
       4. The plan of treatment including:
           a. Medication history, medications prescribed, including the strength, amount, and directions for use and refills;
           b. Therapy or other prescribed regimen; and
           (d) Follow-up plans, including consultation, referrals, and return appointments.
   (3) A medical chart organization and documentation shall, at a minimum, contain the following:
       (a) Enrollee identification information on each page;
       (b) Enrollee date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses, and telephone numbers (if applicable), employer (if applicable), school (if applicable), name and telephone number of an emergency contact, consent form, language spoken, and guardianship information (if applicable);
       (c) Date of data entry and of the encounter;
       (d) Provider’s name;
       (e) Any known allergies or adverse reactions of the enrollee;
       (f) Enrollee’s past medical history;
       (g) Identification of any current problem;
       (h) If a consultation, laboratory, or radiology report is filed in the medical record, the ordering provider’s initials or other documentation indicating review;
       (i) Documentation of immunizations;
       (j) Identification and history of nicotine, alcohol use, or substance abuse;
       (k) Documentation of notification of reportable diseases and conditions to the local health department serving the jurisdiction in which the enrollee resides or to the Department for Public Health pursuant to 902 KAR 2:020;
       (l) Follow-up visits provided secondary to reports of emergency room care;
       (m) Hospital discharge summaries;
       (n) Advance medical directives for adults; and
       (o) All written denials of service and the reason for each denial.

Section 13. Provider Surveys. (1) An MCO shall:
   (a) Conduct an annual survey of provider satisfaction of the quality and accessibility to a service provided by an MCO;
   (b) Annually assess the need for conducting other surveys to support quality and performance improvement initiatives;
   (c) Submit to the department for approval the survey tool used to conduct the survey referenced in paragraph (a) of this subsection; and
   (d) Provide to the department:
       1. A copy of the results of the provider surveys referenced in paragraph (a) of this subsection;
       2. A description of a methodology to be used to conduct surveys;
       3. The number and percentage of providers surveyed;
       4. Provider survey response rates;
       5. Provider survey findings; and
       6. Interventions conducted or planned by the MCO related to activities in this section.
   (2) The department shall:
       (a) Approve provider survey instruments prior to implementation; and
       (b) Approve or disapprove an MCO’s provider survey tool within fifteen (15) days of receipt of the survey tool.
Section 14. Cost Reporting Information. The department shall provide to the MCO the calculation of Medicaid allowable costs as used in the Medicaid Program.

Section 15. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies or does not provide federal financial participation for the policy; or
(2) Disapproves the policy.

LAWRENCE KISSNER, Commissioner
AUDREY TAYE HAYNES, Secretary
APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2013 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email jill.brown@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen (502) 564-4321
(1) Provide a brief summary of:
(a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) requirements and policies relating to providers. Previously, those policies were contained in one (1) administrative regulation (907 KAR 1:705) which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3)). Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. Though this is a new administrative regulation, it does contain a couple of amended policies. The amendments include clarifying that the Department for Medicaid Services (DMS) has authority to determine if an MCO’s provider network is inadequate; and adding a proximity requirement (mileage and time) for enrollee’s access to providers which previously had no proximity requirement (pharmacies, dentists, general vision, laboratory and radiological services); and eliminating an enrollee’s place of employment as a measuring point in determining the enrollee’s access to providers.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to providers. The amendments are necessary to clarify DMS’s authority in assessing the adequacy of an MCO’s provider network; to establish provider access requirements (enrollee proximity to providers) for provider types for which no proximity (distance/time) requirements existed; in order to ensure recipients have reasonable access to those provider types; and to eliminate an enrollee’s place of employment as a proximity (to providers) measuring point as this was impractical as DMS lacks place of employment information for enrollees (whereas DMS does possess longitudinal and latitudinal information for enrollee residences and providers.)
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to providers. The amended policies conform to the content of the authorizing statutes by clarifying or improving policies based on a year of experience and analysis.
(d) How this administrative regulation currently assists or will assist in the effective administration of the administrative regulation: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to providers. The amended policies conform to the content of the authorizing statutes by clarifying or improving policies based on a year of experience and analysis.
(e) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(2) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently there are over 700,000 such individuals) and the Commonwealth (as provider). This administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.

(4) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.
(b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.
(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438. This administrative regulation establishes MCO provider requirements. Those requirements are established in 42 C.F.R. 438.12, 42 C.F.R. 438.52, and 42 C.F.R. 438.206 through 42 C.F.R. 438.208.

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation, and in accordance with any requirements that may be imposed or opportunity that may be presented by federal law, nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation establishes MCO provider requirements. Those requirements include the following: MCOs must not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification (if an MCO, PIHP, or PAHP declines to include individual or groups of providers in its network, it must provide written notification of the reason for its decision; MCOs must give allow enrollees to receive services from out-of-network providers in appropriate circumstances including: (1) when the network cannot provide the necessary services; (2) the only network provider refuses to perform the service on moral or religious grounds; (3) the recipient's primary care provider or other provider determines that the recipient needs related services that would present unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network; MCOs must give enrollees a free choice of family planning providers; MCOs must demonstrate that it has the capacity to serve the expected enrollment in the service area, including assurances that the organization offers an appropriate range of services and access to preventive and primary care services and maintains a sufficient number, mix, and geographic distribution of service providers; MCOs must meet access standards including:

1. Timely access to care and services, taking into account the urgency of the need for services;
2. Hours of operation for network providers that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees;
3. Services available 24 hours a day, 7 days a week, when medically necessary;
4. Direct access for female enrollees to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services - this is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

5. Second opinion from a qualified health care professional within the network, or arrangements for the enrollee to obtain one outside the network, at no cost to the enrollee; and

6. Participation in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse other cultural and ethnic backgrounds.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care but does not impose additional or stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A managed care method of administering the program is being implemented but stricter requirements are not imposed. A managed care program is not federally mandated for Medicaid programs.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

4. Identify each state or federal regulation that requires or authorizes the action taken by this administrative regulation.

5. Fiscal note: No cost is necessary to implement this administrative regulation.

6. Source of primary care if that source is not a women's health specialist; Other Explanation: Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office
(393-341-2020)
1396n(b), 42 C.F.R. Part 438

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.500(5) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the Medicaid managed care organization service and service coverage requirements and policies.

Section 1. MCO Service Areas. An MCO’s service areas shall be as established in the MCO Service Areas.

Section 2. Covered Services. (1) Except as established in subsection (2) of this section, an MCO shall be responsible for the provision of a covered health service:
(a) Which is established in Title 907 of the Kentucky Administrative Regulations;
(b) Which shall be in the amount, duration, and scope that the services are covered for recipients pursuant to the department’s administrative regulations located in Title 907 of the Kentucky Administrative Regulations; and
(c) Beginning on the date of enrollment of a recipient into the MCO.
(2) Other than a nursing facility cost referenced in subsection (3)(i) of this section, an MCO shall be responsible for the cost of a non-nursing facility covered service provided to an enrollee during the first thirty (30) days of a nursing facility admission in accordance with this administrative regulation.
(3) An MCO shall not be responsible for the provision or costs of the following:
(a) A service provided to a recipient in an intermediate care facility for individuals with mental retardation or a developmental disability;
(b) A service provided to a recipient in a 1915(c) home and community based waiver program;
(c) A hospice service provided to a recipient in an institution;
(d) A nonemergency transportation service provided in accordance with 907 KAR 3:066;
(e) Except as established in Section 6 of this administration regulation, a school-based health service;
(f) A service not covered by the Kentucky Medicaid Program;
(g) A health access nurturing development service pursuant to 907 KAR 3:140;
(h) An early intervention program service pursuant to 907 KAR 1:270;
(i) A nursing facility service for an enrollee during the first thirty (30) days of a nursing facility admission.

(4) The following covered services provided by an MCO shall be accessible to an enrollee without a referral from the enrollee’s primary care provider:
(a) A primary care vision service;
(b) A primary dental or oral surgery service;
(c) An evaluation by an orthodontist or a prosthodontist;
(d) A service provided by a women’s health specialist;
(e) A family planning service;
(f) An emergency service;
(g) Maternity care for an enrollee under age eighteen (18);
(h) An immunization for an enrollee under twenty-one (21);
(i) A screening, evaluation, or treatment service for a sexually transmitted disease or tuberculosis;
(j) Testing for HIV, HIV-related condition, or other communicable disease; and
(k) A chiropractic service.
(5) An MCO shall:
(a) Not require the use of a network provider for a family planning service;
(b) In accordance with 42 C.F.R. 431.51(b), reimburse for a family planning service provided within or outside of the MCO’s provider network;
(c) Cover an emergency service:
1. In accordance with 42 U.S.C. 1396u-2(b)(2)(A)(i);
2. Provided within or outside of the MCO’s provider network; or
3. Out-of-state in accordance with 42 C.F.R. 431.52;
(d) Comply with 42 U.S.C. 1396u-2(b)(A)(ii); and
(e) Be responsible for the provision and reimbursement of a covered service as described in this section beginning on or after the beginning date of enrollment of a recipient with an MCO as established in 907 KAR 17:010.

(6)(a) If an enrollee is receiving a medically necessary covered service the day before enrollment with an MCO, the MCO shall be responsible for the reimbursement of continuation of the medically necessary covered service without prior approval and without regard to whether services are provided within or outside the MCO’s network until the MCO can reasonably transfer the enrollee to a network provider.
(b) An MCO shall comply with paragraph (a) of this subsection without impeding service delivery or jeopardizing the enrollee’s health.

Section 3. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. (1) An MCO shall provide an enrollee under the age of twenty-one (21) years with EPSDT services in compliance with:
(a) 907 KAR 11:034; and
(b) 42 U.S.C. 1396d(r).
(2) A provider of an EPSDT service shall meet the requirements established in 907 KAR 11:034.

Section 4. Emergency Care, Urgent Care, and Poststabilization Care. (1) An MCO shall provide to an enrollee:
(a) Emergency care twenty-four (24) hours a day, seven (7) days a week; and
(b) Urgent care within forty-eight (48) hours.
(2) Poststabilization services shall be provided and reimbursed in accordance with 42 C.F.R. 422.113(c) and 428.114(e).

Section 5. Maternity Care. An MCO shall:
(1) Have procedures to assure:
(a) Prompt initiation of prenatal care; or
(b) Continuation of prenatal care without interruption for a woman who is pregnant at the time of enrollment;
(2) Provide maternity care that includes:
(a) Prenatal;
(b) Delivery;
(c) Postpartum care; and
(d) Care for a condition that complicates a pregnancy; and
(3) Perform all the newborn screenings referenced in 902 KAR 4:030.

Section 6. Pediatric Interface. (1) An MCO shall:
(a) Have procedures to coordinate care for a child receiving a school-based health service or an early intervention service; and
(b) Monitor the continuity and coordination of care for the child receiving a service referenced in paragraph (a) of this subsection as part of its quality assessment and performance improvement (QAPI) program established in 907 KAR 17:025.
(2) Except when a child’s course of treatment is interrupted by a school break, after-school hours, or summer break, an MCO shall not be responsible for a service referenced in subsection (1)(a) of this section.
(3) A school-based health service provided by a school district shall not be covered by an MCO.
(4) A school-based health service provided by a local health department shall be covered by an MCO.

Section 7. Pediatric Sexual Abuse Examination. (1) An MCO shall enroll at least one (1) provider in its network who has the capacity to perform a forensic pediatric sexual abuse examination.
(2) A forensic pediatric sexual abuse examination shall be conducted for an enrollee at the request of the DCBS.

Section 8. Lock-in Program. (1) An MCO shall have a program to control utilization of:
(a) Drugs and other pharmacy benefits; and
(b) Non-emergency care provided in an emergency setting.
Section 9. Pharmacy Benefit Program. (1) An MCO shall:  
(a) Have a pharmacy benefit program that shall have:  
1. A point-of-sale claims processing service;  
2. Prospective drug utilization review;  
3. An accounts receivable process;  
4. Retrospective utilization review services;  
5. Formulary and non-formulary drugs;  
6. A prior authorization process for drugs;  
7. Pharmacy provider relations;  
8. A toll-free call center that shall respond to a pharmacy or a physician prescriber twenty-four (24) hours a day, seven (7) days a week; and  
9. A seamless interface with the department’s management information system;  
(b) Maintain a preferred drug list (PDL);  
(c) Provide the following to an enrollee or a provider:  
1. PDL information; and  
2. Pharmacy cost sharing information; and  
(d) Have a Pharmacy and Therapeutics Committee (P&T Committee), which shall:  
1. Meet periodically throughout the calendar year as necessary; and  
2. Make recommendations to the MCO for changes to the drug formulary.  
(2)(a) The department shall comply with the drug rebate collection requirement established in 42 U.S.C. 1396b(m)(5)(A)(xiii);  
(b) An MCO shall:  
1. Cooperate with the department in complying with 42 U.S.C. 1396b(m)(2)(A)(xiii);  
2. Assist the department in resolving a drug rebate dispute with a manufacturer; and  
3. Be responsible for drug rebate administration in a non-pharmacy setting.  
(3) An MCO’s P&T committee shall meet and make recommendations to the MCO for changes to the drug formulary.  
(4) If a prescription for an enrollee is for a non-preferred drug and the pharmacist cannot reach the enrollee’s primary care provider or the MCO for approval and the pharmacist determines it necessary to provide the prescribed drug, the pharmacist shall:  
(a) Provide a seventy-two (72) hour supply of the prescribed drug; or  
(b) Provide less than a seventy-two (72) hour supply of the prescribed drug, if the request is for less than a seventy-two (72) hour supply.  
(5) Cost sharing imposed by an MCO shall not exceed the cost sharing limits established in 907 KAR 1:604.  

Section 10. MCO Interface with the Department Regarding Behavioral Health. An MCO shall:  
(1) Meet with the department monthly to discuss:  
(a) Serious mental illness and serious emotional disturbance operating definitions;  
(b) Priority populations;  
(c) Targeted case management and peer support provider certification training and processes;  
(d) IMPACT Plus program operations;  
(e) Satisfaction survey requirements;  
(f) Priority training topics;  
(g) Behavioral health services hotline; or  

(h) Behavioral health crisis services;  
(2) Coordinate:  
(a) An IMPACT Plus covered service provided to an enrollee in accordance with 907 KAR 3:030;  
(b) With the department:  
1. An enrollee education process for:  
   a. Individuals with a serious mental illness; and  
   b. Children or youth with a serious emotional disturbance; and  
2. On establishing a collaborative agreement with a:  
   a. State-operated or stated-contracted psychiatric hospital; and  
   b. Facility that provides a service to an individual with a co-occurring behavioral health and developmental and intellectual disabilities; and  
(c) With the department and community mental health centers a process for integrating a behavioral health service hotline; and  
(3) Provide the department with proposed materials and protocols for the enrollee education referenced in subsection (2)(b) of this section.  

Section 11. Behavioral Health Services. (1) An MCO shall:  
(a) Provide a medically necessary behavioral health service to an enrollee in accordance with the access standards established in 907 KAR 17:015;  
(b) Use the DSM-IV multi-axial classification system to assess an enrollee for a behavioral service;  
(c) Have an emergency or crisis behavioral health toll-free hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week;  
(d) Not operate one (1) hotline to handle both an emergency or crisis call and a routine enrollee call; and  
(e) Not impose a maximum call duration limit.  
(2) Staff of a hotline referenced in subsection (1)(c) of this section shall:  
(a) Communicate in a culturally competent and linguistically accessible manner to an enrollee; and  
(b) Include or have access to a qualified behavioral health professional to assess and triage a behavioral health emergency.  
(3) A face-to-face emergency service shall be available:  
(a) Twenty-four (24) hours a day; and  
(b) Seven (7) days a week.  

Section 12. Coordination Between a Behavioral Health Provider and a Primary Care Provider. (1) An MCO shall:  
(a) Require a PCP to have a screening and evaluation procedure for the detection and treatment of, or referral for, a known or suspected behavioral health problem or disorder;  
(b) Provide training to a PCP in its network on:  
1. Screening and evaluating a behavioral health disorder;  
2. The MCO’s referral process for a behavioral health service;  
3. Coordination requirements for a behavioral health service; and  
4. Quality of care standards;  
(c) Have policies and procedures that shall be approved by the department regarding clinical coordination between a behavioral health service provider and a PCP:  
(d) Establish guidelines and procedures to ensure accessibility, availability, referral, and triage to physical and behavioral health care;  
(e) Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;  
(f) Identify a method to evaluate continuity and coordination of care; and  
(g) Include the monitoring and evaluation of the MCO’s compliance with the requirements established in paragraphs (a) to (f) of this subsection in the MCO’s quality improvement plan.  
(2) With consent from an enrollee or the enrollee’s legal guardian, an MCO shall require a behavioral health service provider to:  
(a) Refer an enrollee with a known or suspected and untreated physical health problem or disorder to their PCP for examination and treatment; and  
(b) Send an initial and quarterly summary report of an enrollee’s behavioral health status to the enrollee’s PCP.
Section 13. Court-Ordered Psychiatric Services. (1) An MCO shall:
(a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-one (21) and over the age of sixty-five (65) who has been ordered to receive the service by a court of competent jurisdiction under the provisions of KRS Chapters 202A and 645;
(b) Not deny, reduce, or negate the medical necessity of an inpatient psychiatric service provided pursuant to a court-ordered commitment for an enrollee under the age of twenty-one (21) or over the age of sixty-five (65);
(c) Coordinate with a provider of a behavioral health service the treatment objectives and projected length of stay for an enrollee committed by a court of law to a state psychiatric hospital; and
(d) Enter into a collaborative agreement with the state-operated or state-contracted psychiatric hospital assigned to the enrollee’s region in accordance with 908 KAR 3:040 and in accordance with the Olmstead decision.

(2) An MCO shall present a modification or termination of a service rendered in subsection (1)(b) of this section to the court with jurisdiction over the matter for determination.

(3)(a) An MCO behavioral health service provider shall:
1. Participate in a quarterly continuity of care meeting with a state-operated or state-contracted psychiatric hospital;
2. Assign a case manager prior to or on the date of discharge of an enrollee from a state-operated or state-contracted psychiatric hospital; and
3. Provide case management services to an enrollee with a severe mental illness and co-occurring developmental disability who is discharged from:
   a. State-operated or state-contracted psychiatric hospital; or
   b. State-operated nursing facility for individuals with severe mental illness.
(b) A case manager and a behavioral health service provider shall participate in discharge planning to ensure compliance with the Olmstead decision.

Section 14. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:
(1) Denies or does not provide federal financial participation for the policy; or
(2) Disapproves the policy.

Section 15. Incorporation by Reference. (1) "MCO Service Areas", November 2012 edition, is incorporated by reference.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.
(3) It may also be obtained online at the department’s Web site at http://www.chfs.ky.gov/dms/incorporated.htm.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2013 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intention to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing cannot be made unless a written request for a transcript is made by the person desiring same. If the public hearing is held and a transcript is made, the requester shall pay all costs associated with the making of the transcript. A transcript of the public hearing will be maintained by the authorizing statutes.

HEARING OR WRITTEN COMMENTS: Comments on the proposed administrative regulation shall be received by the authorizing statutes by giving MCOs more flexibility in designing a lock-in program.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT
Contact Person: Stuart Owen
(1) Provide a brief summary of:
(a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) service and service coverage requirements and policies. Previously, those policies were contained in one (1) administrative regulation - (907 KAR 17:005) – which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3)). Region three (3) is a sixteen (16) county region which includes Jefferson County and provides complete (1) MCO lock-in services. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulations Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. The only amended policies in this administrative regulation are the inclusion of region three (3) counties for all MCOs; the elimination of the requirement that an MCO’s lock-in program must be in accordance with DMS’s lock-in regulation (907 KAR 1:677); and eliminating the Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule from being incorporated by reference. MCOs must submit their lock-in programs to DMS for approval but the MCOs’ lock-in programs will no longer be required to be in accordance with DMS’s lock-in regulation. The lock-in program is a program which identifies high utilizers of services and implements controls to ensure that utilization is necessary and not excessive.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization service and service coverage requirements and policies. Amending the service coverage regions is necessary as the MCO service coverage policies now apply to MCOs operating in region three (3) as DMS is now contracting with four (4) such entities and is repealing the old administrative regulation which applied to the lone entity which was responsible for managed care in region three (3). The lock-in program amendment is necessary to give MCOs more flexibility in designing a lock-in program. Deleting the Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule from being incorporated by reference is necessary as there is no need to incorporate the document by reference into this administrative regulation.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization service and service coverage requirements and policies. The amended policy conforms to the content of the authorizing statutes by giving MCOs more flexibility in designing a lock-in program (which also may benefit DMS as DMS can measure the success of the MCOs’ lock-in programs and learn from the MCOs’ experiences).
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing Medicaid managed care organ-
ization service and service coverage requirements and policies. The amended policy will assist in the effective administration of the authorizing statutes by giving MCOs more flexibility in designing a lock-in program (which also may benefit DMS as DMS can monitor the success of the MCOs' lock-in programs and learn from the MCOs' experiences.)

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS's projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.
(b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS's projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438. This administrative regulation established MCO service and service coverage requirements and policies. Those requirements are established in 42 C.F.R. 438.114, 42 C.F.R. 438.206 through 438.210.

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for Medicaid purposes. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation establishes MCO service and service coverage requirements. Federal MCO service and service coverage requirements include that MCOs must offer members all services available under the state Medicaid program's state plan; MCOs must cover emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager; An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual in serious jeopardy, (2) serious impairment to bodily function, or (3) serious dysfunction of a bodily organ or part; MCOs must cover services needed to evaluate the emergency and stabilize the patient for transfer or discharge and if the treating physician or provider deems necessary, a nonparticipating provider may continue treatment to improve or resolve the patient's condition if the MCO does not respond to a request for authorization within one hour; a plan physician assumes responsibility for the patient's care, or the emergency professional and the plan physician disagree about the appropriate treatment; and MCOs must comply with the maternity and mental health requirements of the Public Health Service Act (PubNo 94-484) insofar as they apply to a health insurance issuer that offers group health insurance coverage.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care but does not impose additional or stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A managed care method of administering the program is being implemented but stricter requirements are not imposed. A managed care program is not federally mandated for Medicaid programs.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.
(c) How much will it cost to administer this program for the first
year? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,198,870,633.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2014 are $3,303,448,347.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office (New Administrative Regulation)

907 KAR 17:025. Managed care organization requirements and policies related to utilization management and quality.

RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R. 438


NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the Medicaid managed care organization requirements and policies relating to utilization management and quality.

Section 1. Utilization Management or UM. (1) An MCO shall:
(a) Have a utilization management program that shall:
1. Meet the requirements established in 42 C.F.R. Parts 431, 438, and 456, and the private review agent requirements of KRS 304.17A, as applicable;
2. Identify, define, and specify the amount, duration, and scope of each service that the MCO is required to offer;
3. Review, monitor, and evaluate the appropriateness and medical necessity of care and services;
4. Identify and describe the UM mechanisms used to:
   a. Detect the under or over utilization of services;
   b. Act after identifying under utilization or over utilization of services;
5. Have a written UM program description in accordance with subsection (2) of this section; and
6. Be evaluated annually by the:
   a. MCO, including an evaluation of clinical and service outcomes; and
   b. Department;
(b) Adopt nationally-recognized standards of care and written criteria that shall be:
1. Based upon sound clinical evidence, if available, for making utilization decisions; and
2. Approved by the department;
(c) Include physicians and other health care professionals in the MCO network in reviewing and adopting medical necessity criteria;
(d) Have:
1. A process to review, evaluate, and ensure the consistency with which physicians and other health care professionals involved in UM apply review criteria for authorization decisions;
2. A medical director who:
   a. Is licensed to practice medicine or osteopathy in Kentucky;
   b. Is responsible for treatment policies, protocols, and decisions; and
   c. Supervises the UM program; and
3. Written policies and procedures that explain how prior authorization data will be incorporated into the MCO’s quality improvement plan;
(e) Submit a request for a change in review criteria for authorization decisions to the department for approval prior to implementation;
(f) Administer or use a CAHPS survey to evaluate and report enrollee satisfaction with the quality of, and access to, care and services in accordance with 907 KAR 17:010; or
(g) Provide written confirmation of an approval of a request for a service within two (2) business days of providing notification of a decision:
1. The initial decision was not in writing; and
2. Requested by an enrollee or provider;
(h) If the MCO uses a subcontractor to perform UM, require the subcontractor to have written policies, procedures, and a process to review, evaluate, and ensure consistency with which physicians and other health care professionals involved in UM apply review criteria for authorization decisions; and
(i) Not provide a financial or other type of incentive to an individual or entity that conducts UM activities to deny, limit, or discontinue a medically necessary service to an enrollee pursuant to 42 C.F.R. 422.208, 42 C.F.R. 438.6(h), and 42 C.F.R. 438.210(e).
(2) A UM program description referenced in subsection (1)(a)5.

(i) of this section shall:
(a) Outline the UM program’s structure;
(b) Define the authority and accountability for UM activities, including activities delegated to another party; and
(c) Include the:
1. Scope of the program;
2. Processes and information sources used to determine service coverage, clinical necessity, and appropriateness and effectiveness;
3. Policies and procedures to evaluate:
   a. Care coordination;
   b. Discharge criteria;
   c. Site of services;
   d. Levels of care;
   e. Triage decisions; and
   f. Cultural competence of care delivery; and
4. Processes to review, approve, and deny services as needed.
(iii) Only a physician with clinical expertise in treating an enrollee’s medical condition or disease shall be authorized to make a decision to deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested by the enrollee or the enrollee’s treating physician.
(iv) A medical necessity review process shall be in accordance with Section 2 of this administrative regulation.

Section 2. Service Authorization and Notice. (1) For the processing of a request for initial or continuing authorization of a service, an MCO shall identify what constitutes medical necessity and establish a written policy and procedure, which includes a timeframe for:
(a) Making an authorization decision; and
(b) If the service is denied or authorized in an amount, duration, or scope which is less than requested, providing a notice to an enrollee and provider acting on behalf of and with the consent of the enrollee.
(2) For an authorization of a service, an MCO shall make a decision:
(a) As expeditiously as the enrollee’s health condition requires; and
(b) Within two (2) business days following receipt of a request for service.
(3) The timeframe for making an authorization decision referenced in subsection (2) of this section may be extended:
(a) By the:
   1. Enrollee, or the provider acting on behalf of and with consent of an enrollee, if the enrollee requests an extension; or
   2. MCO, if the MCO:
a. Justifies to the department, upon request, a need for additional information and how the extension is in the enrollee’s interest;
b. Gives the enrollee written notice of the extension, including the reason for extending the authorization decision timeframe and the right of the enrollee to file a grievance if the enrollee disagrees with that decision; and
c. Makes and carries out the authorization decision as expeditiously as the enrollee’s health condition requires and no later than the date the extension expires; and

(b) Up to fourteen (14) additional calendar days.

(4) If an MCO denies a service authorization or authorizes a service in an amount, duration, or scope which is less than requested, the MCO shall provide a notice:

(a) To the:
   1. Enrollee, in writing, as expeditiously as the enrollee’s condition requires and within two (2) business days of receipt of the request for service; and
   2. Requesting provider, if applicable;

(b) Which shall:
   1. Meet the language and formatting requirements established in 42 C.F.R. 438.404;
   2. Include the:
      a. Action the MCO or its subcontractor, if applicable, has taken or intends to take;
      b. Reason for the action;
      c. Right of the enrollee or provider who is acting on behalf of the enrollee to file an MCO appeal;
      d. Right of the enrollee to request a state fair hearing;
      e. Procedure for filing an appeal and requesting a state fair hearing;
   f. Circumstance under which an expedited resolution is available, including how to request it; and
   g. Right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstance under which the enrollee may be required to pay the costs of these services; and

3. Be provided:
   a. At least ten (10) days before the date of action if the action is a termination, suspension, or reduction of a covered service authorized by the department, department designee, or enrollee’s MCO, except the department may shorten the period of advance notice to five (5) days before the date of action because of probable fraud by the enrollee;
   b. By the date of action for the following:
      (i) The death of a member;
      (ii) A signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services in which the enrollee understands this will be the result of supplying the information;
      (iii) The enrollee’s address is unknown and mail directed to the enrollee has no forwarding address;
      (iv) The enrollee has been accepted for Medicaid services by another local jurisdiction;
   (v) The enrollee’s admission to an institution results in the enrollee’s ineligibility for more services;
   (vi) The enrollee’s physician prescribes a change in the level of medical care;
   (vii) An adverse decision has been made regarding the predmission screening requirements for a nursing facility admission, pursuant to 907 KAR 1:755 and 42 U.S.C. 1396r(b)(3)(F), on or after January 1, 1989; or
   (viii) The safety or health of individuals in a facility would be endangered, if the enrollee’s health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the enrollee’s urgent medical needs, or an enrollee has not resided in the nursing facility for thirty (30) days;
   c. On the date of action, if the action is a denial of payment and the service has not been provided to the member;
   d. If expeditiously as the enrollee’s health condition requires and within two (2) business days following receipt of a request;
   e. When the MCO carries out its authorization decision, as expeditiously as the enrollee’s health condition requires and no later than the date the extension as identified in subsection (3) of this section expires;
   f. If a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the enrollee’s life or health, or ability to attain, maintain, or regain maximum function, as expeditiously as the enrollee’s health condition requires and no later than two (2) business days after receipt of the request for service; and
   g. For an authorization decision not made within the timeframe identified in subsection (2) of this section, on the date the timeframe expires as this shall constitute a denial.

Section 3. Health Risk Assessment. An MCO shall:

(1) After the initial implementation of the MCO program, conduct an initial health risk assessment of each enrollee within ninety (90) days of enrolling the individual if the individual has not been enrolled with the MCO in a prior twelve (12) month period;

(2) Use health care professionals in the health risk assessment process;

(3) Screen an enrollee who it believes to be pregnant within thirty (30) days of enrollment;

(4) If an enrollee is pregnant, refer the enrollee for prenatal care;

(5) Use a health risk assessment to determine an enrollee’s need for:
      (a) Care management;
      (b) Disease management;
      (c) A behavioral health service;
      (d) A physical health service or procedure; or
      (e) A community service.

Section 4. Care Coordination and Management. An MCO shall:

(1) Have a care coordinator and a case manager who shall:
      (a) Arrange, assure delivery of, monitor, and evaluate care, treatment, and services for an enrollee; and
      (b) Not duplicate or supplant services provided by a targeted case manager to:

         1. Adults with a chronic mental illness pursuant to 907 KAR 1:515;
         2. Children with a severe emotional disability pursuant to 907 KAR 1:525;

(2) Establish guidelines for care coordination that shall be approved by the department prior to implementation;

(3) Develop a plan of care for an enrollee in accordance with 42 C.F.R. 438.208;

(4) Have policies and procedures to ensure access to care coordination for a DCBS client or a DAIL client;

(5) Provide information on and coordinate services with the Washington Infants and Children program; and

(6) Provide information to an enrollee and a provider regarding:
      (a) An available care management service; and
      (b) How to obtain a care management service.

Section 5. Quality Assessment and Performance Improvement (QAPI) Program. An MCO shall:

(1) Have a quality assessment and performance improvement (QAPI) program that shall:
      (a) Conform to the requirements of 42 C.F.R. 438.200 to 438.242;
      (b) Assess, monitor, evaluate, and improve the quality of care provided to an enrollee;
      (c) Provide for the evaluation of:
            1. Access to care;
            2. Continuity of care;
            3. Health care outcomes; and
            4. Services provided or arranged for by the MCO;
      (d) Demonstrate the linkage of quality improvement (QI) activities to findings from a quality evaluation; and
      (e) Be developed in collaboration with input from enrollees;

(2) Submit annually to the department a description of its QAPI program;

(3) Conduct and submit to the department an annual review of the program;

(4) Maintain documentation of:
      (a) Enrollee input;
(b) The MCO’s response to the enrollee input;  
(c) A performance improvement activity; and  
(d) MCO feedback to an enrollee;  
(5) Have or obtain within four (4) years of initial implementation National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line;  
(6) If the MCO has obtained NCQA accreditation:  
(a) Submit to the department a copy of its current certificate of accreditation with a copy of the complete accreditation survey report; and  
(b) Maintain the accreditation;  
(7) Integrate behavioral health service indicators into its QAPI program;  
(8) Include a systematic, on-going process for monitoring, evaluating, and improving the quality and appropriateness of a behavioral health service provided to an enrollee;  
(9) Collect data, monitor, and evaluate for evidence of improvement to a physical health outcome resulting from integration of behavioral health into an enrollee’s care; and  
(10) Annually review and evaluate the effectiveness of the QAPI program.

Section 6. Quality Assessment and Performance Improvement Plan. (1) An MCO shall:  
(a) Have a written QAPI work plan that:  
1. Outlines the scope of activities;  
2. Is submitted quarterly to the department; and  
3. Sets goals, objectives, and timelines for the QAPI program;  
(b) Set new goals and objectives:  
1. At least annually; and  
2. Based on a finding from:  
   a. A quality improvement activity or study;  
   b. A survey result;  
   c. A grievance or appeal;  
   d. A performance measure; or  
   e. The external quality review organization;  
(c) Be accountable to the department for the quality of care provided to an enrollee;  
(d) Obtain approval from the department for its QAPI program and annual QAPI work plan;  
(e) Have an accountable entity within the MCO:  
1. To provide direct oversight of its QAPI program; and  
2. To review reports from the quality improvement committee referenced in paragraph (h) of this subsection;  
(f) Review its QAPI program annually;  
(g) Modify its QAPI program to accommodate a review finding or concern of the MCO if a review finding or concern occurs;  
(h) Have a quality improvement committee that shall:  
1. Be responsible for the QAPI program;  
2. Be interdisciplinary;  
3. Include:  
   a. Providers and administrative staff; and  
   b. Health professionals with knowledge of and experience with individuals with special health care needs;  
4. Meet on a regular basis;  
5. Document activities of the committee;  
6. Make committee minutes and a committee report available to the department upon request; and  
7. Submit a report to the accountable entity referenced in paragraph (e) of this subsection that shall include:  
   a. A description of the QAPI activities;  
   b. Progress on objectives; and  
   c. Improvements made;  
   (i) Require a provider to participate in QAPI activities in the provider agreement or subcontract; and  
   (j) Provide feedback to a provider or a subcontractor regarding integration of or operation of a corrective action necessary in a QAPI activity if a corrective action is necessary.  
(2) If a QAPI activity of a provider or a subcontractor is separate from an MCO’s QAPI program, the activity shall be integrated into the MCO’s QAPI program.

Section 7. QAPI Monitoring and Evaluation. (1) Through its QAPI program, an MCO shall:  
(a) Monitor and evaluate the quality of health care provided to an enrollee;  
(b) Study and prioritize health care needs for performance measurement, performance improvement, and development of practice guidelines;  
(c) Use a standardized quality indicator:  
1. To assess improvement, assure achievement of at least a minimum performance level, monitor adherence to a guideline, and identify a pattern of over and under utilization of a service; and  
2. Which shall be:  
   a. Supported by a valid data collection and analysis method; and  
   b. Used to improve clinical care and services;  
(d) Measure a provider performance against a practice guideline and a standard adopted by the quality improvement committee;  
(e) Use a multidisciplinary team to analyze and address data and systems issues; and  
(f) Have practice guidelines that shall:  
1. Be:  
   a. Disseminated to a provider, or upon request, to an enrollee;  
   b. Based on valid and reliable medical evidence or consensus of health professionals;  
   c. Reviewed and updated; and  
   d. Used by the MCO in making a decision regarding utilization management, a covered service, or care education;  
2. Consider the needs of enrollees; and  
3. Include consultation with network providers.  
(2) If an area needing improvement is identified by the QAPI program, the MCO shall take a corrective action and monitor the corrective action for improvement.

Section 8. Quality and Member Access Committee. (1) An MCO shall:  
(a) Have a quality and member access committee (QMAC) composed of:  
1. Enrollees who shall be representative of the enrollee population; and  
2. Individuals from consumer advocacy groups or the community who represent the interests of enrollees in the MCO; and  
(b) Submit to the department annually a list of enrollee representatives participating in the QMAC.  
(2) A QMAC shall be responsible for reviewing:  
(a) Quality and access standards;  
(b) The grievance and appeals process;  
(c) Policy modifications needed based on reviewing aggregate grievance and appeals data;  
(d) The member handbook;  
(e) Enrollee education materials;  
(f) Community outreach activities; and  
(g) MCO and department policies that affect enrollees.  
(3) The QMAC shall provide the results of its reviews to the MCO.

Section 9. External Quality Review. (1) In accordance with 42 U.S.C. 1396a(a)(30), the department shall have an independent external quality review organization (EQRO) annually review the quality of services provided by an MCO.  
(2) An MCO shall:  
(a) Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Parts 433 and 438; and  
(b) Cooperate and participate in external quality review activities in accordance with the protocol established in 42 C.F.R. 438 Subpart E, 438.310 to 438.370.  
(3) The department shall have the option of using information from a Medicare or private accreditation review of an MCO in accordance with 42 C.F.R. 438.360.  
(4) If an adverse finding or deficiency is identified by an EQRO conducting an external quality review, an MCO shall correct the finding or deficiency.

Section 10. Health Care Outcomes. An MCO shall:  
(1) Comply with the requirements established in 42 C.F.R.
(2) Collaborate with the department to establish a set of unique Kentucky Medicaid managed care performance measures which shall:
(a) Be aligned with national and state preventive initiatives; and
(b) Focus on improving health;
(3) In collaboration with the department and the EQRO, develop a performance measure specific to individuals with special health care needs;
(4) Report activities on performance measures in the QAPI work plan established in Section 6 of this administrative regulation;
(5) Submit an annual report to the department after collecting performance data which shall be stratified by:
(a) Medicaid eligibility category;
(b) Race;
(c) Ethnicity;
(d) Gender; and
(e) Age;
(6) Collect and report HEDIS data annually; and
(7) Submit to the department:
(a) The final auditor’s report issued by the NCQA certified audit organization; and
(b) A copy of the interactive data submission system tool used by the MCO.

Section 11. Performance Improvement Projects (PIPs). (1) An MCO shall:
(a) Implement PIPs to address aspects of clinical care and nonclinical services;
(b) Collaborate with local health departments, behavioral health agencies, and other community-based health or social service agencies to achieve improvements in priority areas;
(c) Initiate a minimum of two (2) PIPs each year with at least one (1) PIP relating to physical health and at least one (1) PIP relating to behavioral health;
(d) Report on a PIP using standardized indicators;
(e) Specify a minimum performance level for a PIP; and
(f) Include the following for a PIP:
1. The topic and its importance to enrolled members;
2. Methodology for topic selection;
3. Goals of the PIP;
4. Data sources and collection methods;
5. An intervention; and
6. Results and interpretations.
(2) A clinical PIP shall address preventive and chronic health-care needs of enrollees including:
(a) The enrollee population;
(b) A subpopulation of the enrollee population; and
(c) Specific clinical need of enrollees with conditions and illnesses that have a higher prevalence in the enrolled population.
(3) A nonclinical PIP shall address improving the quality, availability, and accessibility of services provided by an MCO to enrollees and providers.
(4) The department may require an MCO to implement a PIP specific to the MCO if:
(a) A finding from an EQRO review referenced in Section 9 of this administrative regulation or an audit indicates a need for a PIP; or
(b) Directed by CMS.
(5) The department shall be authorized to require an MCO to assist in a statewide PIP which shall be limited to providing the department with data from the MCO’s service area.

Section 12. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:
(1) Denies or does not provide federal financial participation for the policy; or
(2) Disapproves the policy.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2013 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:
CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email jill.brown@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT
Contact Person: Stuart Owen
(1) Provide a brief summary of:
(a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) requirements and policies relating to utilization management and quality. Previously, those policies were contained in one (1) administrative regulation - (907 KAR 17:005) – which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3)). Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is not changing the addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. The only amended policy in this administrative regulation is the elimination of the MCO reporting requirements as incorporating the material is unnecessary.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to utilization management and quality. The amendment is necessary to prevent the unnecessary incorporation by reference of a document into an administrative regulation.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to utilization management and quality.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to utilization management and quality.

FILED WITH LRC: December 21, 2012 at 4 p.m.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
  (a) How the amendment will change this existing administrative regulation; This is a new administrative regulation.
  (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
  (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
  (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.
(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently, there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.
(4) An analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
  (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.
  (b) If complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3)? No cost is imposed.
  (c) As a result of compliance, what benefits will accrue to the entities identified in question (3)? The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.
(5) Provide an estimate of how much it will cost to implement this administrative regulation:
  (a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.
  (b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.
(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.
(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.
(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.
(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438. This administrative regulation established MCO utilization management and quality requirements and policies. Quality assessment and performance improvement requirements are established in 42 C.F.R. 438.200 through 438.242. External quality review is another required quality component and those requirements are established in 42 C.F.R. 438.310 through 438.370.
2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."
3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation establishes MCO utilization management and quality requirements. Quality assessment and performance improvement requirements are established in 42 C.F.R. 438.200 through 438.242. External quality review is another required quality component and those requirements are established in 42 C.F.R. 438.310 through 438.370. Quality requirements include the following: States must develop and implement a quality assessment and improvement strategy, including:
   (1) standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care, adequate primary care, and specialized services: (2) examinations of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards); (3) procedures for monitoring and evaluating the quality and propriety of care and services, including the submission of quality assurance data; and (4) regular, periodic examinations of the scope and content of the quality improvement strategies. Also, states must provide for an annual external independent review conducted by a qualified independent entity (an external quality review organization or EQRO) of the quality outcomes, timeliness, and access to items and services for which the organization is responsible under the contract. The results are available to participating healthcare providers, enrollees, and potential enrollees of the organization in a manner that does not disclose the identity of an individual patient. An EQRO must meet the experience and independence criteria at 42 C.F.R. §438.354, which require that there be no financial or contractual relationship between the state agency and the organization.
4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care (which is not federally mandated) but does not impose additional or stricter requirements than the federal managed care organization requirements.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not being imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.
2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.
3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is in effect.
   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.
   (c) How much will it cost to administer this program for the first year? None.
year? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,198,870,633.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2014 are $3,303,448,347.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner’s Office
(New Administrative Regulation)

907 KAR 17:030. Managed care organization operational and related requirements and policies.

RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R. 438


NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the Medicaid managed care organization operational and related requirements and policies.

Section 1. Prompt Payment of Claims. (1) In accordance with 42 U.S.C. 1396a(a)(37), an MCO shall have prepayment and post-payment claims review procedures that ensure the proper and efficient payment of claims and management of the program.

(2) An MCO shall:
(a) Comply with the prompt payment provisions established in 1. 42 C.F.R. 447.45; and
2. KRS 205.593, KRS 304.14-135, and KRS 304.17A-700 to 304.17A-730; and

(b) Notify a requesting provider of a decision to:
1. Deny a claim; or
2. Authorize a service in an amount, duration, or scope that is less than requested.

(3) The payment provisions in this section shall apply to a payment to:
(a) A provider within the MCO network; and
(b) An out-of-network provider.

Section 2. Payments to an MCO. (1) The department shall provide an MCO a per enrollee, per month capitation payment whether or not the enrollee receives a service during the period covered by the payment except for an enrollee whose eligibility is determined due to being unemployed in accordance with 45 C.F.R. 233.100.

(2) The monthly capitation payment for an enrollee whose eligibility is determined due to being unemployed shall be prorated from the date of eligibility.

(3) A capitation rate referenced in subsection (1) of this section shall:
(a) Meet the requirements of 42 C.F.R. 438.6(c); and
(b) Be approved by the Centers for Medicare and Medicaid Services.

(4)(a) The department shall apply a risk adjustment to a capitation rate in an amount that shall be budget neutral to the department.

(b) The department shall use the latest version of the Chronic Illness and Disability Payment System to determine the risk adjustment referenced in paragraph (a) of this subsection.

Section 3. Recoupment of Payment from an Enrollee for Fraud, Waste, or Abuse. (1) If an enrollee is determined to be ineligible for Medicaid through an administrative hearing or adjudication of fraud by the CHFS OIG, the department shall recoup a capitation payment it has made to an MCO on behalf of the enrollee.

(2) An MCO shall request a refund from the enrollee referenced in subsection (1) of this section of a payment the MCO has made to a provider for the service provided to the enrollee.

(3) If an MCO has been unable to collect a refund referenced in subsection (2) of this section within six (6) months, the Commonwealth shall have the right to recover the refund from the enrollee.

Section 4. MCO Administration. An MCO shall have executive management responsible for operations and functions of the MCO that shall include:

(1) An executive director who shall:
(a) Act as a liaison to the department regarding a contract between the MCO and the department;
(b) Be authorized to represent the MCO regarding an inquiry pertaining to a contract between the MCO and the department;
(c) Have decision making authority; and
(d) Be responsible for following up regarding a contract inquiry or issue;

(2) A medical director who shall be:
(a) A physician licensed to practice medicine in Kentucky;
(b) Actively involved in all major clinical programs and quality improvement components of the MCO; and

(c) Available for after-hours consultation;
(3) A dental director who shall be:
(a) Licensed by a dental board of licensure in any state;
(b) Actively involved in all oral health programs of the MCO; and
(c) Available for after-hours consultation;

(4)(a) A finance officer who shall oversee the MCO’s budget and accounting systems; and
(b) An internal auditor who shall ensure compliance with adopted standards and review expenditures for reasonableness and necessity;

(5) A quality improvement director who shall be responsible for the operation of:
(a) The MCO’s quality improvement program; and
(b) A subcontractor’s quality improvement program;

(6) A behavioral health director who shall be:
(a) A behavioral health practitioner;
(b) Actively involved in all of the MCO’s programs or initiatives relating to behavioral health; and
(c) Responsible for the coordination of behavioral health services provided by the MCO or any of its behavioral health subcontractors;

(7) A case management coordinator who shall be responsible for coordinating and overseeing case management services and continuity of care for MCO enrollees;

(8) An early and periodic screening, diagnosis, and treatment (EPSDT) coordinator who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for MCO enrollees;

(9) A foster care and subsidized adoption care liaison who shall serve as the MCO’s primary liaison for meeting the needs of an enrollee who is:
(a) A child in foster care; or
(b) A child receiving state-funded adoption assistance;

(10) A guardianship liaison who shall serve as the MCO’s primary liaison for meeting the needs of an enrollee who is a ward of the Commonwealth;

(11) A management information systems director who shall oversee, manage, and maintain the MCO’s management information system;

(12) A program integrity coordinator who shall coordinate, manage, and oversee the MCO’s program integrity functions;
Section 5. Health Care Data Submission and Penalties. (1) (a) An MCO shall maintain an original encounter record and denial encounter record, if any, to the department weekly.
   
(b) An original encounter record or a denial encounter record shall be considered late if not received by the department within four (4) calendar days from the weekly due date.
   
(c) Beginning on the fifth calendar day late, the department shall withhold $500 per day for each day late from an MCO’s total capitation payments per day until the corrected encounter record is received and accepted by the department.
   
2. Except as provided in subsection (2) of this section, if the MCO’s management information system:
   
(a) Has the capacity to:
   
1. Capture and provide the required data captured by the subsystems listed in subsection (1)(a)2. of this section; and
   2. Provide the data in formats and files that shall be consistent with the subsystems listed in subsection (1)(a)2. of this section; and
   
(b) Meets the requirements established in paragraph (a) of this subsection in a way which shall be mapped to the subsystem concept established in subsection (1)(a)2. of this section.
   
3. If an MCO subcontracts for services, the MCO shall provide guidelines for its subcontractor to the department for approval.

Section 8. Management Information System. (1) An MCO shall:
   
(a) Have a management information system that shall:
   1. Provide support to the MCO operations; and
   2. Except as provided in subsection (2) of this section, include:
   
(a) Member subsystem;
   b. Third party liability subsystem;
   c. Provider subsystem;
   d. Reference subsystem;
   e. Claim processing subsystem;
   f. Financial subsystem;
   g. Utilization and quality improvement subsystem; and
   h. Surveillance utilization review subsystem; and
   
b) Transmit data to the department in accordance with 42 C.F.R. 438.242.

(2) An MCO’s management information system shall not be required to have the subsystems listed in subsection (1)(a)2. of this section if the MCO’s management information system:
   
(a) Has the capacity to:
   
1. One (1) year of enrollment in the MCO’s network; or
   2. A timeframe approved by the department if greater than one (1) year; and
   
(b) Encourage a provider in its network to establish connectivity with the KHIE.
   
(3) The department shall:
   
(a) Administer an electronic health record incentive payment program; and
   
b) Inform an MCO of a provider that has received an electronic health record incentive payment.

Section 10. MCO Qualifications and Maintenance of Records. (1) An MCO shall:
   
(a) Be licensed by the Department of Insurance as a health maintenance organization or an insurer;
   
(b) Have a governing body;
   
(c) Have protection against insolvency in accordance with:
   1. 806 KAR 3:190; and
   2. 42 C.F.R. 438.116;
   
(d) Maintain all books, records, and information related to MCO providers, recipients, or recipient services, and financial transactions for:
   
1. A minimum of five (5) years in accordance with 907 KAR 1:672; and
   
2. Any additional time period as required by federal or state law; and
   
(e) Submit a request for disclosure of information subject to open records laws, KRS 61.870 to 61.884, received from the public to the department within twenty-four (24) hours.
   
(2) Information shall not be disclosed by an MCO pursuant to a request it received pursuant to subsection (1)(e) of this section without prior written authorization from the department.
   
(3) The books, records, and information referenced in subsection (1)(d) of this section shall be available upon request of a reviewer or auditor during routine business hours at the MCO’s place of operations.
   
(4) MCO staff shall be available upon request of a reviewer or auditor during routine business hours at the MCO’s place of operations.
Section 11. Prohibited Affiliations. The policies or requirements:
(1) Imposed on a managed care entity in 42 U.S.C. 1396u-2(d)(1) shall apply to an MCO; and
(2) Established in 42 C.F.R. 438.610 shall apply to an MCO.

Section 12. Termination of MCO Participation in the Medicaid Program. If necessary, a contract with an MCO shall be terminated and the termination shall be in accordance with KRS Chapter 45A.

Section 13. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:
(1) Denies or does not provide federal financial participation for the policy; or
(2) Disapproves the policy.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: December 18, 2012
FILED WITH LRC: December 21, 2012 at 4 p.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2013 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email jill.brown@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen
(1) Provide a brief summary of:
(a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) operational and related requirements. Previously, those policies were contained in one (1) administrative regulation – (907 KAR 17:005) – which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3). Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3). The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is dividing the policies across multiple regulations in response to urgent from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. The only amended policy in this administrative regulation is the elimination of the MCO reporting requirements, the Management Information System Requirements, the Third Party Liability/Coordination of Benefits as incorporating the materials is unnecessary.
(b) How this administrative regulation fits within the administration: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to utilization management and quality. The amendment is necessary to prevent the unnecessary incorporation by reference of documents into an administrative regulation.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to utilization management and quality.
(d) How this administrative regulation currently assists or will assist in the effective administration of the authorizing statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to utilization management and quality.
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
(d) How the amendment will assist in the effective administration of the authorizing statutes: This is a new administrative regulation.
(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently, there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.
(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) have to take to comply with this administrative regulation or amendment: No action is required.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3)? No cost is imposed.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.
(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,198,870,633.
(b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS’s projected managed care expenditures for state fiscal year (SFY 2013) are $3,303,448,347.
(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.
(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.
(8) State whether or not this administrative regulation estab-
lishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 C.F.R. Part 438. This administrative regulation established MCO operational and related requirements.

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds, the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 C.F.R. Part 438. This administrative regulation establishes MCO operational and related requirements and those requirements include: MCOs are required to make adequate provisions against the risk of insolvency. A provision meets the requirements for a plan if the plan meets the solvency standards established by the state for private plans, nonprofit corporations, nonprofit trusts, or the state, as a risk-bearing entity; recipients must be protected from any liability in case of insolvency or failure to receive payment from the state; an MCO may not affiliate knowingly with individuals debased, suspended, or otherwise excluded from doing business with the federal government; an MCO may not have such an individual as a director, officer, partner, or person with beneficial ownership of more than five (5) percent of the entity's equity; an MCO may not have an employee, contractor, consultant, or other agreement with such an individual for the provision of items and services that are significant and material to the entity's obligations under its contract with the state; an MCO may not enter into a contract with any state that does not have in effect conflict-of-interest safeguards with respect to officers and employees of the state with responsibilities relating to contracts with such organizations or to the default enrollment provisions that are at least as effective as the federal safeguards provided under §27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423); an MCO must require each physician providing services to eligible enrollees have a unique identifier; States must establish standards for a range of intermediate sanctions that a state may impose on plans that: (1) fail to provide medically necessary items and services; (2) impose excessive premiums or charges; (3) discriminate against enrollees on the basis of health status; (4) misrepresent or falsify information; or (5) fail to comply with the applicable requirements of federal law on payment to Medicaid-participating HMOs regarding physician incentive plans; states may also impose intermediate sanctions against a managed care entity that improperly distributes marketing materials; intermediate sanctions may consist of civil money penalties; states may terminate a contract with an MCO and enroll the entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the state plan other than through a managed care entity); the Centers for Medicare and Medicaid Services (CMS) must review and approve all contracts with MCOs; and MCOs pay affiliated healthcare providers for items and services on a timely basis in accordance with the federal law deadlines for claims payment unless the healthcare provider and the organization agree to an alternate payment schedule.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care (which is not federally mandated) but does not impose additional or stricter requirements than the federal managed care organization requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not being imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be impacted by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? No cost is necessary to implement this amended administrative regulation. DMS’s projected managed care expenditures for SFY 2013 are $3,198,870,633.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? None.

(d) How much will it cost to administer this program for subsequent years? None.

4. Identify each state or federal regulation that is impacted by this administrative regulation.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? None.

(d) How much will it cost to administer this program for subsequent years? None.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not being imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be impacted by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438 and this administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? None.

(d) How much will it cost to administer this program for subsequent years? None.

4. Identify each state or federal regulation that is impacted by this administrative regulation.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? None.

(d) How much will it cost to administer this program for subsequent years? None.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not being imposed.
Call to Order and Roll Call

The January 2013 meeting of the Administrative Regulation Review Subcommittee was held on Monday, January 7, 2013, at 1:00 p.m., in Room 149 of the Capitol Annex. Senator Joe Bowen, Co-chair, called the meeting to order, the roll call was taken. The minutes of the December 2012 meeting were approved.

Present were:
Members: Senators Joe Bowen, Perry Clark, David Givens, and Alice Forgy Kerr, and Representatives Johnny Bell, Robert Damron, Jimmie Lee, and Tommy Turner.

LRC Staff: Dave Nicholas, Emily Caudill, Donna Little, Sarah Amburgey, Emily Harkenrider, Karen Howard, Betsy Cupp, and Laura Napier.

Guests: Whitney A. Crowe, Education Professional Standards Board; Beau Barnes, Kentucky Teachers’ Retirement System; Tom Crawford, DeVen Hankins, Doug Hendrix, Bethany Rice, Finance and Administration Cabinet; Dr. Preston Nunnelly, Michael Rodman, Lloyd Vest, Kentucky Board of Medical Licensure; Ryan Halloran, George Purvis, Board of Speech-Language Pathology and Audiology; Ryan Halloran, Board of Licensure and Certification for Dieticians and Nutritionists; Shelli Deskins, Ryan Halloran, Kentucky Applied Behavior Analysis Board; William Balda, Margaret Everson, Dr. Jon Gassett, Tim Slone, Dr. Karen Waldrop; Department of Education; Dawn M. Bellis, William Swope, Department of Corrections; Susan Allred, Kevin Brown, David Couch, Kentucky Department for Natural Resources; Amy Barker, Department of Housing, Buildings and Construction; Stephanie Brammer-Barnes, Mary Reine Begley, Virginia Carrington, Elizabeth Caywood, U. Eneje, Dr. Stephen Hall, Stephanie Hold, Mary Beth Jackson, Diona Mullins, Stuart Owen, Connie Smith, Chandra Venettozzi, Cabinet for Health and Family Services; Bill Doll, Kentucky Medical Association; and John Daniels and Derek Humfleet, Central Kentucky Wellness Center.

The Administrative Regulation Review Subcommittee met on Monday, January 7, 2013, and submits this report:

Administrative Regulations Reviewed by the Subcommittee:

EDUCATIONAL PROFESSIONAL STANDARDS BOARD: Assessment
16 KAR 6:010. Examination prerequisites for teacher certification.
A motion was made and seconded to approve the following amendments: to amend Section 2 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Advanced Certification and Rank
16 KAR 8:030. Continuing Education Option for certificate renewal and rank change.
A motion was made and seconded to approve the following amendments: (1) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Sections 3, 4, 6, 7, and 8 to comply with the drafting and formatting requirements of KRS Chapter 13A; and (2) to amend Section 4 to clarify that the performance indicators are listed in the CEO Professional Development Portfolio Rubric incorporated by reference. Without objection, and with agreement of the agency, the amendments were approved.

FINANCE AND ADMINISTRATION CABINET: Kentucky Teachers’ Retirement System: General Rules
102 KAR 1:310. Benefit eligibility conditions for members providing part-time and substitute services. Beau Barnes, deputy ex-

ecutive secretary of operations and general counsel, represented the system.
A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and NECESSITY, FUNCTION AND CONFORMITY paragraphs to correct statutory citations; and (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220. Without objection, and with agreement of the agency, the amendments were approved.

102 KAR 1:340. Calculation of final average salary when there is a corresponding change in length of employment during any of the final three (3) years immediately prior to retirement.
A motion was made and seconded to approve the following amendments: (1) to amend the TITLE and Section 1 to comply with the drafting and formatting requirements of KRS Chapter 13A; and (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220. Without objection, and with agreement of the agency, the amendments were approved.

Department of Revenue: Office of Property Valuation: Ad Valorem Tax; Administration
103 KAR 5:220 & E. Installment payment plan guidelines for third party purchasers of certificates of delinquency. Tom Crawford, director; Doug Hendrix, staff attorney; and Bethany Rice, attorney, represented the office.
A motion was made and seconded to approve the following amendments: (1) to amend Section 1 to cite to statutory definitions; (2) to amend the RELATES TO and STATUTORY AUTHORITY paragraphs and Sections 1 through 6 and 8 to comply with the drafting and formatting requirements of KRS Chapter 13A; and (3) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220. Without objection, and with agreement of the agency, the amendments were approved.

GENERAL GOVERNMENT CABINET: Board of Medical Licensure: Board
201 KAR 9:001 & E. Definitions for terms used in 201 KAR Chapter 9. Dr. Preston Nunnelley, president; Michael Rodman, executive director; and Lloyd Vest, general counsel, represented the board.
In response to a question by Co-Chair Bowen, Mr. Vest stated that this administrative regulation clarified terms used in the authorizing statute. There had been confusion regarding certain terms. Co-Chair Bowen stated that it appeared that this administrative regulation defined terms used only in the statute, not in this chapter of administrative regulations, which would be a violation of KRS 13A.222(4)(e). Mr. Vest stated that the statute authorized the agency to promulgate an administrative regulation to govern prescribing and dispensing; therefore, the board had authority to define terms related to prescribing and dispensing.
Co-Chair Bell stated that this administrative regulation was needed and if it did not continue through the process, there may be disruptions in continuity of care for patients. Mr. Vest stated that this administrative regulation had universal support. The concern was that, without these definitions, continuity of care for patients would be negatively impacted. Because these provisions were codified as a criminal statute, failure to clarify these definitions could result in inappropriate criminal liability, the threat of which may discourage physicians from prescribing appropriate pain medication.
In response to a question from Co-Chair Bowen, Subcommittee staff stated that KRS 13A.222(4)(d) and (e) established requirements for definitions in administrative regulations. Terms defined in an administrative regulation were required to be used in that administrative regulation or chapter of administrative regulations, but many of the terms defined in this administrative regulation were not used in this chapter. Additionally, some of the defini-
Representative Damron stated that the Subcommittee’s focus should be on protecting the intent of the General Assembly and protecting the citizens. There was an agreement to reconsider House Bill 1 from the 2012 Special Session of the General Assembly, and it appeared to need more revision to address concerns that arose in conjunction with this administrative regulation package; however, it was important to allow this administrative regulation to continue through the normal administrative regulation process because failure to do so may be detrimental to healthcare for the citizens. Representative Damron directed the board to proactively cooperate with revising House Bill 1 from the 2012 Special Session of the General Assembly during the 2013 Regular Session of the General Assembly. If the board failed to do so, the Subcommittee had authority to recall this administrative regulation for consideration. Senator Givens reiterated that this administrative regulation would be recalled if necessary.

In response to questions by Representative Lee, Mr. Vest agreed to reconsider House Bill 1 from the 2012 Special Session of the General Assembly and stated that the process was already underway to propose amendments. Dr. Nunnelley stated that patients periodically needed to be released from long-term use of prescription pain medicine, and that sometimes happened after reassessment, which may indicate why some physicians stopped prescribing pain medication after passage of this legislation. Additionally, some physicians were concerned about legal liability pursuant to the new statutory provisions. Physicians were obligated in the interest of patient health to titrate gradually from pain medicine that had been prescribed for long-term use. There was a narrow line the board had to consider in drafting administrative regulations: the balance between preventing drug abuse and appropriately treating those patients who legitimately needed long-term pain management. This administrative regulation was not perfect, but much better with the amendments considered.

Co-Chair Bowen emphasized the overarching concern with this administrative regulation, which was that the emergency administrative regulation became effective with very little notification to stakeholders. Dr. Nunnelley restated that the board was committed to resolving issues with House Bill 1 from the 2012 Special Session of the General Assembly during the 2013 Regular Session of the General Assembly. Senator Kerr noted that Dr. Nunnelley was a professional of integrity and could be depended on to follow through with working to revise the legislation.

A motion was made and seconded to approve the following amendments: (1) to amend the TITLE and NECESSITY, FUNCTION, AND CONFORMITY paragraph to specify that this administrative regulation establishes definitions for terms used in KRS 218A.172, rather than for 201 KAR chapter 9; and (2) to add a definition of “patient when functioning within the scope of a hospice program”. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 9:081 & E. Disciplinary proceedings.
A motion was made and seconded to approve the following amendments: (1) to amend the STATUTORY AUTHORITY paragraph to add a statutory citation; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; (3) to amend Section 1 to: (a) alphabetize the definitions as required by KRS 13A.222(4)(e); and (b) add a definition of “relating to a controlled substance”; (4) to amend Section 2 relating to grievances and investigations, to require the board to provide specified information to a party who wants to register a grievance against a physician; (5) to amend Section 3 relating to reports and recommendations to specify that the panel chair or inquiry panel, rather than the executive director, may make determinations to issue a complaint; (6) to amend Section 7 to specify that a notice shall be issued as required by KRS 13B.050; (7) to amend Section 8 to specify that: (a) a hearing officer shall be appointed in accordance with KRS 13B.030 and (b) the board’s general counsel or assistant general counsel shall act as the prosecuting attorney; and (c) the provisions of KRS Chapter 13B shall govern the conduct of each proceeding; (8) to delete the provisions of Section 9, relating to meetings of the board and panels, as those are internal proceedings that are excluded from administrative regulations by KRS 13A.010(2)(a); (9) to amend Section 10 to move a definition from this section to Section 1, as required by KRS 13A.222(4)(d) and (e); (10) to create a new Section 11 to incorporate by reference documents relating to the filing of a grievance; and (11) to amend Sections 1 through 10 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 9:200 & E. National Practitioner Data Bank reports.
A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and STATUTORY AUTHORITY paragraphs to correct statutory citations; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; and (3) to amend Section 1 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 9:210 & E. Criminal background checks required for all new applicants.
A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and STATUTORY AUTHORITY paragraphs to correct statutory citations; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; and (3) to amend Section 1 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 9:220 & E. Restriction upon dispensing of Schedule II controlled substances and Schedule III controlled substances containing Hydrocodone.
A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and STATUTORY AUTHORITY paragraphs to correct statutory citations; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; and (3) to amend the TITLE and Section 1 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 9:230 & E. Required registration in the KASPER system; legal requirements for prescribing controlled substances in the Commonwealth of Kentucky; enforcement.
In response to a question by Senator Givens, Mr. Vest stated that the initial proposal for this administrative regulation, which was reflected in the emergency administrative regulation, was based on the board’s desire to place the statutory requirements and the regulatory provisions all in the administrative regulation to avoid having to use two (2) sets of law in concert. Because KRS 13A.120(2)(e) prohibited repealing statutory language in an administrative regulation, the ordinary administrative regulation was amended to comply. Differences between the emergency administrative regulation and the ordinary administrative regulation were not substantive.
A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO paragraph to correct statutory citations; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; (3) to amend Sections 1 and 2 to: (a) delete provisions that repeated or summarized existing statutory provisions; and (b) require a licensee to have both a valid DEA permit and KASPER registration as required by KRS 218A.202 to prescribe or dispense a controlled substance and to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.
201 KAR 9:240 & E. Emergency orders and hearings; appeals and other proceedings.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO paragraph to correct statutory daily citation to amended statute; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; (3) to amend Section 1, relating to the authority to issue an emergency order, to: (a) delete provisions that repeated or summarized statutory provisions; and (b) authorize an inquiry panel or the panel’s chair to issue an emergency order in accordance with KRS 311.592 and 31B.125; (4) to amend Section 3, relating to emergency orders of suspension following a felony indictment, to clarify that if the board receives verifiable information that a licensee has been indicted for a felony that relates to a controlled substance, an emergency order shall be issued to suspend or restrict that licensee’s Kentucky license to prohibit the licensee from prescribing, dispensing, or otherwise utilizing a controlled substance in Kentucky, until further order following the final resolution of the criminal charges in the indictment; (5) to amend Section 5, relating to emergency hearings, to: (a) delete provisions that repeated KRS 13B.090(5); (b) require that the emergency hearing be conducted as required by KRS Chapter 13B and Section 5(6) of this administrative regulation; (c) delete provisions that provided that refusal of the affected physician to answer board questions shall be considered an interference with the board’s ability and a rescission of the physician’s request for an emergency hearing; and (d) delete provisions that required the affected physician to reimburse the contractual reviewer (the board’s expert witness) as a pre-requisite for cross-examining the reviewer; (6) to amend Section 6, relating to judicial review, to: (a) delete provisions that repeated or summarized statutory provisions; and (b) require that judicial review of a final order comply with the board’s ability and a rescission of the physician’s request for an emergency hearing; and (7) to amend Sections 1 through 6 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 9:250 & E. Registration and oversight of pain management facilities.

In response to a question by Co-Chair Bowen, Mr. Vest stated that the agency proposed substantive amendments because the board realized this administrative regulation needed clarification. This administrative regulation governed pain management facilities.

A motion was made and seconded to approve the following amendments: (1) to amend Section 1(3) to clarify as part of the definition of “pain management facility” that each separate operating location of a physician’s practice that meets the criteria established by the statutory definition shall be considered a separate pain management facility; (2) to amend Section 4(5) to require that the required registration and annual fee be submitted by September 1, rather than August 1, of each year, to be consistent with similar changes made in the Amended After Comments version; (3) to amend Section 5(5) to require a facility to notify the board within fourteen (14), rather than ten (10), days of each change in physician staffing of the facility, to be consistent with similar changes made in the Amended After Comments version; (4) to amend Section 6(3) to: (a) correct a formatting error; and (b) to specify that any violation of KRS 218A.175(3) or that section regarding on-site supervision shall constitute a violation of KRS 311.595(12) and (9); (5) to amend Section 7 to require a pain management facility to maintain any daily sign-in sheets maintained by the practice and to permit assess to those daily sign-in sheets by a board employee or agent; and (6) to amend Section 8 to provide that the board may establish proof that a clinic, practice, or facility is a pain management facility by looking at any selected thirty (30) day period to determine if: (a) the majority of patients receiving medical treatment from the clinic, practice, or facility received controlled substances or a prescription for controlled substances; and (b) one of the requirements of KRS 218A.175(1)(a) were present during that thirty (30) day period. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 9:260 & E. Professional standards for prescribing and dispensing controlled substances. Bill Doll, attorney, represented Jack-son Kelly PLLC’s client, Kentucky Medical Association, and appeared in opposition to this administrative regulation.

Mr. Doll stated that this administrative regulation and House Bill 1 from the 2012 Special Session of the General Assembly needed parity in order to perform their functions to protect patients and appropriately treat patients with long-term pain management issues. Physicians were discouraged from treating patients with long-term pain management issues because of concerns regarding civil and criminal liability. Mr. Doll advocated using clinical guidelines and advisory opinions to guide decisions regarding the appropriateness of prescribing long-term pain medication. Punitive measures resulted in stifling physicians from prescribing needed medication. The bill’s provisions have had over burdensome unintended consequences.

In response to comments by Mr. Doll, Mr. Vest stated that the Kentucky Board of Medical Licensure had not historically used some of the discretion authorized by the General Assembly in the board’s authorizing statutes. This discretion was left unused in efforts to provide flexibility to physicians. The board attempted to find a balance between the prevention of drug abuse and appropriate treatment of patients with long-term pain management issues. This administrative regulation protected citizens from potential drug abuse, while still providing physicians the flexibility that they needed. This administrative regulation was consistent with federal standards.

In response to a question by Representative Lee, Mr. Rodman stated that the board would follow up with information regarding how many specialty pain management physicians were certified in Kentucky.

A motion was made and seconded to approve the following amendments: (1) to amend the STATUTORY AUTHORITY paragraph to add a statutory citation; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph on clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; (3) to amend this administrative regulation to: (a) require a facility to provide information to the board regarding the physician’s practice that meets the criteria established by the statutory definition, to clarify that if the board receives verifiable information from a physician requesting an emergency order to protect patients from potential drug abuse, the physician determined that the controlled substance prescribed to the patient will be used or is likely to be used other than medicinally or otherwise than for an accepted therapeutic purpose; (5) to amend Section 8, relating to educational materials, to delete the statement that educational materials were incorporated by reference; and (6) to amend Section 10 with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 9:310 & E. Continuing medical education.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO paragraph to add a statutory citation; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; (3) to amend Section 1 to require that a licensee submit the Continuing Medical Education Certification Form by the renewal deadline established in another administrative regulation; (4) to amend Section 4 to specify the requirements for requesting an extension of time for meeting the continuing medical education requirements; (5) to amend Section 6 to specify the continuing medical education requirements for each cycle that is affected by the effective date of House Bill 1, July 20, 2012; (6) to amend Section 10 to incorporate by reference the required forms relating to continuing medical education requirements; (7) to amend the two (2) forms incorporated by reference to conform to the substantive provisions of this administrative regulation; and (8) to amend Section 1 through 10 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.
A motion was made and seconded to approve the following amendments: (1) to amend Sections 2 and 10 to delete effective dates that would have preceded the effective date of the administrative regulation; and (2) to amend Section 10 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 17:110. Telehealth and telepractice.

A motion was made and seconded to approve the following amendments: (1) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; and (2) to amend Sections 1, 2, and 4 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Board of Licensure and Certification for Dietitians and Nutritionists: Board

201 KAR 33:015. Application; approved programs. Ryan Hallooran, assistant attorney general, represented the board.

A motion was made and seconded to approve the following amendments: to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Sections 1 and 2 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Kentucky Applied Behavior Analysis Licensing Board: Board

201 KAR 43:050. Requirements for supervision. Shelli Deskins, chair, and Ryan Hallooran, assistant attorney general, represented the board.

A motion was made and seconded to approve the following amendments: (1) to amend Section 2 to clearly establish the standards for supervisors; and (2) to amend Sections 4, 5, 7, 8, 9, and 11 through 15 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

TOURISM, ARTS AND HERITAGE CABINET: Department of Fish and Wildlife Resources: Game

301 KAR 2:142. Spring wild turkey hunting. Margaret Everson, assistant attorney general; Dr. Jon Gassett, commissioner; and Dr. Karen Waldrop, wildlife division director, represented the department.


301 KAR 2:221 & E. Waterfowl seasons and limits.

301 KAR 2:222 & E. Waterfowl hunting requirements on public lands.

A motion was made and seconded to approve the following amendments: to amend Section 4 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

301 KAR 2:224 & E. Waterfowl hunting zones.

ENERGY AND ENVIRONMENT CABINET: Department for Environmental Protection: Division of Water: Water Quality

401 KAR 5:055. Scope and applicability of the KPDES Program. Peter Goodmann, assistant director, and R. Bruce Scott, commissioner, represented the division.

In response to questions by Senator Givens, Mr. Scott stated that the requirement that the cabinet shall consult with U.S. EPA’s regional administrator before approval of innovative technology was not a new requirement, but was inadvertently omitted from Section 10(3) of this administrative regulation during the previous revision. U.S. EPA had federal authority to approve or disapprove of the innovative technology after the cabinet’s consultation.

401 KAR 5:060. KPDES application requirements.

Department for Natural Resources: Division of Mine Reclamation and Enforcement: Surface Effect of Noncoal Mining

405 KAR 5:032. Permit requirements. James McKenziel, assistant director, and Michael Mullins, regulatory coordinator, represented the division.

In response to a question by Co-Chair Bell, Mr. McKenziel stated that this administrative regulation did not relate to stockpiles and silos. This administrative regulation revised the format for submission of maps.

A motion was made and seconded to approve the following amendments: to amend Sections 8, 21, 26, and 27 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

JUSTICE AND PUBLIC SAFETY CABINET: Department of Corrections: Office of the Secretary


A motion was made and seconded to approve the following amendments: to amend Section 1 and policy KSP 13-02-13 to correct the amount a nonindigent inmate shall pay for replacement eye glasses from the original charge of $15.50 to the actual cost charged by the supplier. Without objection, and with agreement of the agency, the amendments were approved.

EDUCATION AND WORKFORCE DEVELOPMENT CABINET: Board of Education: Department of Education: Office of Chief State School Officer

701 KAR 5:110. Use of local monies to reduce unmet technology need. Susan Allred, associate commissioner; Kevin Brown, general counsel; and David Couch, associate commissioner, represented the department.

In response to a question by Representative Arron, Ms. Allred stated that there was not a request for a public hearing; therefore, the department canceled the public hearing. The department received written comments from the public during the public comment period. The comments concerned changing “require” to “shall.” Additionally, there was a comment that this administrative regulation was an unfunded mandate. This administrative regulation was about innovation and trying not to limit alternative options. Training was necessary to ensure a quality program.

Mr. Brown stated that this was the second version of this administrative regulation and was developed after stakeholder input. Mr. Couch stated that the department made changes in response to public comments. This version was to improve the existing program.

In response to a question by Co-Chair Bowen, Mr. Brown stated that it was not unusual for the department not to get many public comments during the public comment period because the department had public hearings at the board level prior to filing an administrative regulation with LRC.

In response to a question by Senator Givens, Mr. Couch stated that this administrative regulation provided for leveraging from all funding sources in order to cover costs for unmet technology needs. This provision was in place since the 1990s.

A motion was made and seconded to approve the following amendments: (1) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation; and (2) to amend Section 3 to: (a) correct the name of the 2013-2018 KETS Master Plan; and (b) specify that the department shall assist districts in selecting equipment, software, and services which will reduce the unmet technology need; and (3) to amend Sections 4 and 5 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Alternative Education Programs


A motion was made and seconded to approve the following amendments: (1) to amend the STATUTORY AUTHORITY para-
graph to correct citations; (2) to amend Section 1 to: (a) define “child with a disability” and “individual education program” consistent with other administrative regulations; and (b) clarify in the definition of “involuntary placement” that it is not made at the request of the parent but legally required; (3) to amend Section 2 to clarify the role of districts for alternative education programs; and (4) to amend Sections 1 through 6 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

PUBLIC PROTECTION CABINET: Department of Housing, Buildings and Construction: Division of Fire Prevention: Standards of Safety

CABINET FOR HEALTH AND FAMILY SERVICES: Office of Health Policy: Certificate of Need
900 KAR 6:075 & E. Certificate of Need nonsubstantive review. Diona Mullins, policy advisor, and Chandra Venettozzi, health data administrator, represented the cabinet.

In response to a question by Co-Chair Bowen, Ms. Mullins stated that no one appeared at the public hearing, but written comments were received during the public comment period.

In response to questions by Senator Givens, Ms. Mullins stated that the statute changed in the 2012 Regular Session of the General Assembly. The statutory revision required the criteria that were established in this administrative regulation.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO paragraph and Section 1 to correct statutory citations; (2) to amend Sections 1 and 2 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Office of Inspector General: Division of Health Care: Health Services and Facilities
902 KAR 20:420 & E. Pain management facilities. Stephanie Brammer-Barnes, policy analyst; Mary Begley, inspector general; and Stephanie Hold, assistant director, represented the division. John Daniels, owner, and Derek Humfleet, attorney, represented Central Kentucky Wellness Center, and appeared but waived commenting on these administrative regulations. Lloyd Vest, general counsel, Kentucky Board of Medical Licensure, appeared to answer questions related to these administrative regulations.

Representative Lee stated that he was concerned about negative unintended consequences that may result from these administrative regulations. Those patients who legitimately need long-term pain management may not get the treatment they need if there are not enough certified physicians who can comply with pain management facility ownership requirements.

In response to a question by Senator Givens, Ms. Begley stated that the division was currently regulating eight (8) nonphysician-owned pain management facilities, which were spread fairly equally throughout the state, rather than being concentrated in one area. There may be other such facilities operating, but they would be operating illegally because they did not register before the deadline established by the law. If the division encountered these illegally operating facilities, it referred them to the cabinet’s Office of Legal Services for closure action.

Co-Chair Bell stated that House Bill 1 from the 2012 Special Session of the General Assembly had dramatically reduced drug abuse; however, there had also been negative unintended consequences. Some legitimate pain management needs were going unmet. In some cases, there was becoming more prevalent use by patients who could no longer get access to legitimate medications for their needs. Ms. Begley stated that the eight (8) facilities regulated by the division were not the only pain management facilities in the state. There were still facilities that were physician owned and therefore were regulated by the Kentucky Board of Medical Licensure, not the division. Mr. Vest stated that the Kentucky Board of Medical Licensure strove to maintain an adequate number of physicians able to serve long-term pain management patients. He added that House Bill 1 from the 2012 Special Session of the General Assembly explicitly required that pain management facilities be wholly physician owned unless the facility met the limited requirements to be nonphysician owned.

In response to a question by Representative Lee, Mr. Vest stated that KMBL would have jurisdiction over a pain management facility that was wholly physician owned. Ms. Begley stated that if a facility was not physician owned, the division standards were different than those of the Kentucky Board of Medical Licensure for wholly physician-owned facilities. KRS 218A.175 required that a physician who wholly owned a pain management facility was required to have certification in pain management. Mr. Vest stated that this was another portion of House Bill 1 from the 2012 Special Session of the General Assembly that needed to be amended during the 2013 Regular Session of the General Assembly in order to achieve parity among related administrative regulations.

In response to a question by Co-Chair Bowen, Mr. Vest stated that he was unaware of a legitimate pain management facility that closed as a result of House Bill 1 from the 2012 Special Session of the General Assembly.

Division of Audits and Investigations: Controlled Substances
902 KAR 55:110 & E. Monitoring system for prescription controlled substances.

A motion was made and seconded at the December 17, 2012 meeting of the Subcommittee to approve the following amendments: (1) to amend the STATUTORY AUTHORITY paragraph to correct statutory citations; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; and (3) to amend Sections 1 through 12 to: (a) comply with the drafting and formatting requirements of KRS Chapter 13A; and (b) delete provisions that restated statutory provisions. Without objection, and with agreement of the agency, the amendments were approved.

Department for Medicaid Services: Division of Healthcare Facilities Management: Psychiatric Residential Treatment Facilities Services and Reimbursement
907 KAR 9:035 & E. Level I and II psychiatric residential treatment facility service and coverage policies. Dr. Stephen Hall, commissioner, and Stuart Owen, regulation coordinator, represented the division.

In response to a question by Representative Lee, Mr. Owen stated that the amendment proposed by Representative Lee provided a per diem payment for each eligible child. For the purposes of calculating occupancy, the amendment would allow payment of the per diem in some cases in which the child may be physically absent, for example, if the child had a therapeutic pass or was attempting to be discharged from a facility. Sometimes a child may be in the process of being discharged and need to return soon because of distress with the discharge process. This administrative regulation raised the reimbursement amount for a hospital bed day. Fifty (50) percent of the rate would be paid if occupancy was at least eighty-five (85) percent. Representative Lee added that mental health care organizations (MCOs) were not obligated to pay for more days than previously required pursuant to this administrative regulation.

In response to a question by Senator Givens, Mr. Owen stated that it was not possible to estimate a fiscal impact because this
was a new level of care category. Utilization was usually covered by managed care. MCOs were involved in conversations prior to the newest version of this administrative regulation and were reluctant to pay for empty beds, but the therapeutic pass was a useful program. Dr. Hall stated that in cases of a therapeutic pass or attempted discharge, the child’s belongings remained in the child’s bedroom at the facility. This process assisted with transitioning children and preventing distress if a child needed to return to the facility.

Co-Chair Bell stated that children often had to be readmitted after an attempt to discharge. There were several MCOs in his district that had outstanding payments that needed to be reconciled.

A motion was made and seconded to approve the following amendments: (1) to amend Section 1 to: (a) revise the definition of “active treatment” to delete “psychiatrist” from the list of individuals who can provide treatment as psychiatrists are already included in the listing under qualified mental health professionals; (b) define “provided by this administrative regulation, as required by KRS 20:320; and (c) clarify the definitions of “review agency” and “tele-medicine”; (2) to amend Section 8 to: (a) require, rather than authorize, the department to cover bed reserve days and therapeutic pass days; (b) require, rather than authorize, the department to allow a recipient to exceed the limit for those days if the department determines it is in the best interest of the recipient; (c) delete the requirement that the psychiatric residential treatment facility have an occupancy rate of at least fifty (50) percent; and (d) specify that an absence due to: 1. an admission to a hospital type facility shall count as an absence for census purposes; and 2. a therapeutic pass day shall not count as an absence for census purposes; (3) to amend Sections 1 through 4, 6, and 8 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

907 KAR 9:010 & E. Reimbursement for Level I and II psychiatric residential treatment facility services.

A motion was made and seconded to approve the following amendments: (1) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function of the division. Chair Bowen stated that it was surprising that the guidelines were not previously a part of these administrative regulations. A motion was made and seconded to approve the following amendments: to amend the RELATES TO paragraph and Sections 1, 4, 5, 6, and 14 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

922 KAR 2:110. Child-care center provider requirements.

A motion was made and seconded to approve the following amendments: to amend the RELATES TO paragraph and Sections 1, 3, and 5 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.


A motion was made and seconded to approve the following amendments: to amend the RELATES TO paragraph and Sections 1 through 5, 7, 9, and 12 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

922 KAR 2:180. Requirements for registered child care providers in the Child Care Assistance Program.

A motion was made and seconded to approve the following amendments: to amend the RELATES TO paragraph and Sections 1, 3, and 5 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

922 KAR 2:190. Civil penalties.

A motion was made and seconded to approve the following amendments: to amend the RELATES TO paragraph and Sections 2, 3, and 6 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.
The following administrative regulations were deferred to the February 11, 2013, meeting of the Subcommittee:

KENTUCKY HIGHER EDUCATION ASSISTANCE AUTHORITY: Division of Student and Administrative Services: Teacher Scholarship Loan Program
11 KAR 8:030. Teacher scholarships.

GENERAL GOVERNMENT CABINET: Board of Licensure for Massage Therapy: Board
201 KAR 42:070. Endorsement.

KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM: Board of Emergency Medical Services: Board
202 KAR 7:520. Allocation of block grant funding assistance for emergency medical services.

ENERGY AND ENVIRONMENT CABINET: Department for Environmental Protection: Division of Water: Water Quality Standards
401 KAR 10:026. Designation of uses of surface waters.
401 KAR 10:031. Surface water standards.

TRANSPORTATION CABINET: Office of the Secretary: Department of Aviation: Airport Zoning Commission
602 KAR 50:030. Jurisdiction of the Kentucky Airport Zoning Commission.
602 KAR 50:050. Airport zoning map.

Department of Highways: Traffic
603 KAR 5:050. Uniform traffic control devices.

The Subcommittee adjourned at 3:35 p.m. until February 11, 2013 at 1 p.m.
COMPILER’S NOTE: In accordance with KRS 13A.290(9), the following reports were forwarded to the Legislative Research Commission by the appropriate jurisdictional committees and are hereby printed in the Administrative Register. The administrative regulations listed in each report became effective upon adjournment of the committee meeting at which they were considered.

INTERIM JOINT COMMITTEE ON HEALTH AND WELFARE
Meeting of December 19, 2012

The following administrative regulations were available for consideration and placed on the agenda of the Interim Joint Committee on Health and Welfare for its meeting of December 11, 2012, having been referred to the Committee on December 5, 2012, pursuant to KRS 13A.290(6):

201 KAR 22:001
201 KAR 22:053
900 KAR 6:030
900 KAR 6:125
910 KAR 1:260

Committee activity in regard to review of the above-referenced administrative regulations is reflected in the minutes of the December 11, 2012 meeting, which are hereby incorporated by reference.
Locator Index - Effective Dates

The Locator Index lists all administrative regulations published in VOLUME 39 of the Administrative Register of Kentucky from July 2012 through June 2013. It also lists the page number on which each administrative regulation is published, the effective date of the administrative regulation after it has completed the review process, and other action which may affect the administrative regulation. NOTE: The administrative regulations listed under VOLUME 38 are those administrative regulations that were originally published in VOLUME 38 (last year’s) issues of the Administrative Register of Kentucky but had not yet gone into effect when the 2012 Kentucky Administrative Regulations Service was published.

KRS Index

The KRS Index is a cross-reference of statutes to which administrative regulations relate. These statute numbers are derived from the RELATES TO line of each administrative regulation submitted for publication in VOLUME 39 of the Administrative Register of Kentucky.

Technical Amendment Index

The Technical Amendment Index is a list of administrative regulations which have had technical, nonsubstantive amendments entered since being published in the 2012 Kentucky Administrative Regulations Service. These technical changes have been made by the Regulations Compiler pursuant to KRS 13A.040(9) and (10) or 13A.312(2). Since these changes were not substantive in nature, administrative regulations appearing in this index will NOT be published in the Administrative Register of Kentucky.

Subject Index

The Subject Index is a general index of administrative regulations published in VOLUME 39 of the Administrative Register of Kentucky, and is mainly broken down by agency.
## LOCATOR INDEX - EFFECTIVE DATES

### VOLUME 38

The administrative regulations listed under VOLUME 38 are those administrative regulations that were originally published in Volume 38 (last year’s) issues of the Administrative Register of Kentucky but had not yet gone into effect when the 2012 Kentucky Administrative Regulations Service was published.

### KEY:
- * Statement of Consideration not filed by deadline
- ** Withdrawn before being printed in Register
- **** Emergency expired after 180 days
- (r) Repealer regulation: KRS 13A.310 on the effective date of an administrative regulation that repeals another, the regulations compiler shall delete the repealed administrative regulation and the repealing administrative regulation.

#### EMERGENCY ADMINISTRATIVE REGULATIONS:
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VOLUME 39
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**SYMBOL KEY:**
- * Statement of Consideration not filed by deadline
- ** Withdrawn, not in effect within 1 year of publication
- *** Withdrawn before being printed in Register
- (r) Repealer regulation: KRS 13A.310-on the effective date of an administrative regulation that repeals another, the regulations compiler shall delete the repealed administrative regulation and the repealing administrative regulation.
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The Technical Amendment Index is a list of administrative regulations which have had technical, nonsubstantive amendments entered since being published in the 2012 Kentucky Administrative Regulations Service. These technical changes have been made by the Regulations Compiler pursuant to KRS 13A.040(9) and (10) or 13A.312(2). Since these changes were not substantive in nature, administrative regulations appearing in this index will NOT be published in the Administrative Register of Kentucky. NOTE: Finalized copies of the technically amended administrative regulations are available for viewing on the Legislative Research Commission Web site at http://www.lrc.ky.gov/home.htm.

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