ADMINISTRATIVE REGISTER OF KENTUCKY

LEGISLATIVE RESEARCH COMMISSION
Frankfort, Kentucky

VOLUME 39, NUMBER 12
SATURDAY, JUNE 1, 2013

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ADMINISTRATIVE REGISTER OF KENTUCKY

LEGISLATIVE RESEARCH COMMISSION
Frankfort, Kentucky

VOLUME 39, NUMBER 12
SATURDAY, JUNE 1, 2013

The submission deadline for this edition of the *Administrative Register of Kentucky* was noon, May 15, 2013.

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MEETING NOTICE: ARRS

The **Administrative Regulation Review Subcommittee** is **tentatively** scheduled to meet June 11, 2013 at 1:00 p.m. in room 149 Capitol Annex. See **tentative agenda** on pages **2293-2394** of this Administrative Register.

EARRS MEETING NOTICE

The Education Assessment and Accountability Review Subcommittee is tentatively scheduled to meet at 1:00 p.m., Tuesday, June 18, 2013 in room 131, Capitol Annex, Frankfort, Kentucky.

The **ADMINISTRATIVE REGISTER OF KENTUCKY** is the monthly supplement for the 2012 Edition of **KENTUCKY ADMINISTRATIVE REGULATIONS SERVICE**.

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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:

Title		Chapter	Regulation
806	KAR	50:	155
Cabinet, Department, Board, or Agency		Office, Division, Board, or Major Function	Specific Regulation

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ADMINISTRATIVE REGULATION REVIEW SUBCOMMITTEE
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GENERAL GOVERNMENT CABINET
Board of Nursing

Board

201 KAR 20:057. Scope and standards of practice of advanced practice registered nurses.
201 KAR 20:070. Licensure by examination.
201 KAR 20:085. Licensure periods and miscellaneous requirements.
201 KAR 20:110. Licensure by endorsement.

KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM
Kentucky Board of Emergency Medical Services

Board

202 KAR 7:520. Allocation of block grant funding assistance for emergency medical services.

TOURISM, ARTS AND HERITAGE CABINET
Department of Fish and Wildlife Resources

Fish

301 KAR 1:015. Boat and motor restrictions.
301 KAR 1:122. Importation, possession, and prohibited aquatic species.

PUBLIC PROTECTION CABINET
Department of Alcoholic Beverage Control

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804 KAR 9:040. Retail liquor package license quota. (Amended After Comments)(Deferred from May)
804 KAR 9:050. Retail liquor drink license quota. (Deferred from April)

Department of Housing, Buildings and Construction
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Kentucky Building Code

815 KAR 7:120. Kentucky Building Code. (Not Amended After Comments) (Deferred from April)

Division of Plumbing

Plumbing

815 KAR 20:020. Parts or materials list.
815 KAR 20:120. Water supply and distribution.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Provider Operations

Payment and Services

907 KAR 3:015 & E. Supplemental payments for certain primary care and vaccines. ("E" expires 9/30/2013)

Department for Community Based Services
Division of Family Support

Food Stamp Program

921 KAR 3:090 & E. Simplified assistance for the elderly program or "SAFE". ("E" expires 9/24/2013)

Commissioner's Office

Child Welfare

922 KAR 1:130 & E. Kinship Care Program. ("E" expires 9/24/2013)
922 KAR 1:140 & E. Foster care and adoption permanency services. ("E" expires 9/24/2013)
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922 KAR 1:400 & E. Supportive services. ("E" expires 9/24/2013)

Division of Child Care

Day Care

922 KAR 2:020. Child Care Assistance Program (CCAP) improper payments, claims, and penalties.
922 KAR 2:090 & E. Child-care center licensure. ("E" expires 9/23/2013)
922 KAR 2:100. Certification of family child-care homes.
922 KAR 2:110. Child-care center provider requirements.
922 KAR 2:120. Child-care center health and safety standards.
922 KAR 2:160 & E. Child Care Assistance Program. ("E" expires 9/23/2013)
922 KAR 2:180. Requirements for registered child care providers in the Child Care Assistance Program.

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GENERAL GOVERNMENT CABINET
Board of Nursing

Board

201 KAR 20:400. Delegation of nursing tasks. (Comments Received, SOC ext.)

KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM
Kentucky Board of Emergency Medical Services

Board

202 KAR 7:330. Requirements for examination, certification, and recertification of the advanced emergency medical technician. (Comments Received, SOC ext.)

202 KAR 7:540. Emergency Medical Services data collection, management, and compliance. (Comments Received, SOC ext.)

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Division of Water

Water Quality

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Water Quality Standards

401 KAR 10:030. Antidegradation policy implementation methodology. (Not Amended After Comments) (Deferred from December)

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Kentucky Board of Education
Department of Education

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702 KAR 4:160. Capital construction process. (Comments Received, SOC ext.)

PUBLIC PROTECTION CABINET
Department of Housing, Buildings and Construction
Division of Plumbing

Plumbing

815 KAR 20:034. Requirements for approval of continuing education courses and providers. (Comments Received)

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Provider Operations

Medicaid Services

907 KAR 1:055 & E. Payments for primary care center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services. ("E" expires 9/27/2013) (Comments Received, SOC ext.)

ADMINISTRATIVE REGULATION REVIEW PROCEDURE - OVERVIEW
(See KRS Chapter 13A for specific provisions)

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.

EMERGENCY ADMINISTRATIVE REGULATIONS

STATEMENT OF EMERGENCY
900 KAR 10:010E

This emergency administrative regulation is being promulgated to establish the criteria for certification as a qualified health plan or qualified dental plan to be offered on the Kentucky Health Benefit Exchange as required by 45 C.F.R Parts 155 and 156. This administrative regulation must be promulgated on an emergency basis: To meet the deadlines and requirements of 42 C.F.R. 155.105, which sets the standards for approval for Kentucky to operate a state-based Exchange. Pursuant to 42 U.S.C. Section 18031, which sets forth the federal requirements in establishing a state-based Exchange, Kentucky must implement procedures for certification, recertification and decertification of qualified health plans. Failure to enact this administrative regulation on an emergency basis will compromise the ability of the Exchange to timely certify health plans as qualified health plans and dental plans as qualified dental plans. Qualified health plans and qualified dental plans are necessary for the provision of health care services provided in the Commonwealth through the Exchange. 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.

Steven L. Beshear, Governor
Audrey Tayse Haynes, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Office of the Kentucky Health Benefit Exchange
(Emergency Administrative Regulation)

900 KAR 10:010E. Exchange Participation Requirements and Certification of Qualified Health Plans and Qualified Dental Plans.

RELATES TO: KRS 194A.050(1), 42 U.S.C. 18031, 45 C.F.R. Parts 155, 156

STATUTORY AUTHORITY: KRS 194A.050(1)

EFFECTIVE: May 13, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Office of the Kentucky Health Benefit Exchange, has responsibility to administer the state-based American Health Benefit Exchange. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet; and to implement programs mandated by federal law or to qualify for the receipt of federal funds. This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan to be offered on the Kentucky Health Benefit Exchange, pursuant to and in accordance with 42 U.S.C. 18031 and 45 C.F.R. Parts 155 and 156.

Section 1. Definitions. (1) "Actuarial value" means the percentage of the total allowed costs of benefits paid by a health plan.

(2) "Affordable Care Act" or "ACA" means the Patient Protection and Affordable Care Act, Public Law 111-148, enacted March 23, 2010 as amended by the Health Care and Education Reconciliation Act, Public Law 111-152, enacted March 30, 2010.

(3) "Agent" is defined by KRS 304.9-020(1).

(4) "Annual open enrollment period" except for the initial open enrollment period, is defined by 45 C.F.R. 155.410(e).

(5) "Benefit year" means a calendar year for which a health plan provides coverage for health benefits.

(6) "Catastrophic plan" means a health plan that is described in and meets the requirements of 45 C.F.R 156.155.

(7) "Certificate of authority" is defined by KRS 304.1-110.

(8) "Certification" means a determination by the Kentucky Health Benefit Exchange that a health plan or a stand-alone dental plan has met the requirements in Sections 2 through 17 of this administrative regulation.

(9) "Child-only plan" means an individual health policy that provides coverage to an individual under twenty-one (21) years of age and meets the requirements of 45 C.F.R 156.200(c)(2).

(10) "Consumer Operated and Oriented Plan" or "CO-OP" means a private, non-profit health insurance issuer established in Section 1322 of the Affordable Care Act that has a certificate of authority.

(11) "Dental Insurer" means an insurer defined by KRS 304.17C-010(4), which offers a limited health service benefit plan for dental services.

(12) "Department of Health and Human Services" or "HHS" means the U.S. Department of Health and Human Services.

(13) "Department of Insurance" or "DOI" is defined by KRS 304.1-050(2).

(14) "Enrollee" means an eligible individual enrolled in a qualified health plan.

(15) "Essential community provider" means a provider determined and approved by HHS as an essential community provider for the Commonwealth of Kentucky.

(16) "Essential community provider category" means a provider as described in "Chapter 7: Instructions for the Essential Community Providers Application Section", as incorporated by reference in this administrative regulation.

(17) "Essential health benefits" means benefits as identified by 42 U.S.C. 18022 and approved by the Secretary of HHS for the Commonwealth of Kentucky.

(18) "Health plan" is defined by 42 U.S.C. 18021(b)(1).

(19) "Indian" is defined by 25 U.S.C. 450b(d).

(20) "Issuer" is defined by 45 C.F.R. 144.103.

(21) "Health plan form" or "form" is defined by 806 KAR 14:007.

(22) "Individual exchange" means the Kentucky Health Benefit Exchange that serves the individual health insurance market.

(23) "Individual market" is defined by KRS 304.17A-005(26).

(24) "Initial open enrollment period" means the period beginning October 1, 2013, and extending through March 31, 2014, during which a qualified individual or qualified employee may enroll in health coverage through an exchange for the 2014 benefit year.

(25) "Kentucky Health Benefit Exchange" or "KHBE" means the Kentucky state-based exchange conditionally approved by HHS pursuant to 45 C.F.R. 155.105 to offer a QHP beginning January 1, 2014.

(26) "Metal level of coverage" means health care coverage provided within plus or minus two (2) percentage points of the full actuarial value as follows:

(a) Bronze level with an actuarial value of 60 percent;

(b) Silver level with an actuarial value of 70 percent;

(c) Gold level with an actuarial value of 80 percent; and

(d) Platinum level with an actuarial value of 90 percent.

(27) "Multi-state plan" means a health plan that is offered under a contract with the U.S. Office of Personnel Management in accordance with Section 1334 of the Affordable Care Act.

(28) "Office of the Kentucky Health Benefit Exchange" or "Office" means the office created to administer the Kentucky Health Benefit Exchange.

(29) "Participating agent" means an agent as defined by KRS 304.9-020(1) who has been certified by the office to participate on the KHBE.

(30) "Participation agreement" means an agreement between the office and the issuer to offer a QHP or qualified dental plan on the KHBE.

(31) "Pediatric dental essential health benefit" means a dental service to prevent disease and promote oral health, restore an oral structure to health and function, and treat an emergency condition provided to an individual under the age of twenty-one (21) years that meets the requirements of 45 C.F.R. 156.110(a)(10).

(32) "Plan management data template" means the data collection templates used to facilitate data submission for certification of qualified health plan issuers and qualified health plans as established in CMS Form Number CMS-10433, as amended.

(33) "Plan year" means a consecutive twelve (12) month period

during which a health plan provides coverage for health benefits.

(34) "Premium" is defined by KRS 304.14-030.

(35) "Provider network" is defined by KRS 304.17A-005(35).

(36) "Qualified dental plan" means a dental plan certified by the KHBE that provides a limited scope of dental benefits as defined in 26 U.S.C. 9832(c)(2)(A), limited to a pediatric dental essential health benefit which complies with the requirements of 45 C.F.R. 156.110(a)(10).

(37) "Qualified employee" means an individual employed by a qualified employer who has been offered health insurance coverage by the qualified employer through the SHOP.

(38) "Qualified employer" means an employer that elects to make, at a minimum, all full-time employees of the employer eligible for one (1) or more QHPs in the small group market offered through the SHOP.

(39) "Qualified health plan" or "QHP" means a health plan that meets the standards described in 45 C.F.R. 156 Subpart C and that has in effect a certification issued by the KHBE.

(40) "Qualified individual" means an individual who has been determined eligible to enroll through the KHBE in a QHP in the individual market.

(41) "Service area" means a geographical area in which an issuer may offer a QHP.

(42) "SHOP" means a Small Business Health Options Program operated by the KHBE through which a qualified employer can provide a qualified employee and their dependents with access to one (1) or more QHPs.

(43) "Small group" is defined by KRS 304.17A-005(42).

(44) "Stand-alone dental plan" means a dental plan as described by 45 C.F.R. 155.1065.

(45) "Summary of Benefits and Coverage" or "SBC" means a standard format, created in accordance with 42 U.S.C. 300gg-15, for providing information to consumers about a health plan's coverage and benefits.

(46) "System for Electronic Rate and Form Filing" or "SERFF" means an online system established and maintained by the National Association of Insurance Commissioners (NAIC) that enables an issuer to send and a state to receive, comment on, and approve or reject rate and form filings.

Section 2. QHP Issuer General Requirements. In order for an issuer to participate in the KHBE beginning January 1, 2014, the issuer shall:

(1) Hold a certificate of authority and be in good standing with the Kentucky Department of Insurance;

(2) Be authorized by the office to participate on the KHBE;

(3) Enter into a participation agreement with the KHBE;

(4) Offer KHBE certified QHPs in the individual exchange or the SHOP exchange;

(5) Comply with benefit design standards as established in 45 C.F.R. 156.20;

(6) Provide coverage of the;

(a) Essential health benefits; or

(b) If stand-alone pediatric dental essential health benefit is offered in the KHBE in accordance with 45 C.F.R 155.1065, essential health benefits excluding pediatric dental essential health benefits;

(7) Implement and report on a quality improvement strategy or strategies consistent with the standards of 42 U.S.C. 18031(g);

(8) Comply with applicable standards described in 45 C.F.R. Part 153;

(9) For the individual exchange, offer at least a:

(a) QHP with a silver metal level of coverage;

(b) QHP with a gold metal level of coverage;

(c) Child-only plan; and

(d) Catastrophic plan.

(10) For the SHOP exchange, offer at least a:

(a) QHP with a silver metal level of coverage; and

(b) QHP with a gold metal level of coverage;

(11) For the individual and SHOP exchange, offer no more than four (4) QHPs within a specified metal level of coverage. For the purposes of establishing the number of QHPs offered in a metal level, the KHBE shall consider the same plan offered with dental benefits and offered without dental benefits as one (1) QHP;

(12) Not discriminate, with respect to a QHP, on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation;

(13) Assure that the non-discrimination requirements in 42 U.S.C. 300gg-5 are met;

(14) If participating in the small group market, comply with KHBE processes, procedures, and requirements established in accordance with 42 C.F.R. 155.705 for the small group market;

(15) Allow a participating agent to:

(a) Enroll individuals, employers, and employees in QHPs offered on the exchange;

(b) Enroll qualified individuals in a QHP in a manner that constitutes enrollment through the KHBE; and

(c) Assist individuals in applying for advance payments of premium tax credit and cost sharing reductions; and

(16)(a) Offer a QHP in a statewide service area, except as allowed under paragraph (b) of this subsection; or

(b) Offer a QHP in a service area less than statewide if:

1. A QHP is available statewide;

2. The issuer's service area includes one (1) or more counties;

3. The issuer's service area is approved by the DOI; and

4. The issuer's service area is established in a nondiscriminatory manner without regard to:

a. Race;

b. Ethnicity;

c. Language;

d. Health status of an individual in a service area; or

e. A factor that excludes a high utilizing, high cost or medically-underserved population.

Section 3. QHP Rate and Benefit Information. (1) A QHP issuer shall:

(a) Comply with the provisions of 45 C.F.R. 156.210 and KRS 304.17A-095(4);

(b) Submit to DOI through the SERFF system:

1. Form filings in compliance with KRS 304.14-120 and applicable administrative regulations promulgated thereunder;

2. Rate filings in compliance with KRS 304.17A-095 and applicable administrative regulations promulgated thereunder;

3. Plan management data templates;

(c) Receive approval from DOI for a rate filing prior to implementation of the approved rate; and

(d) For a rate increase, post the justification prominently on the QHP issuer's Web site.

(2) A CO-OP, multi-state plan, and qualified dental plan shall comply with requirements identified by subsection (1) of this section.

Section 4. QHP Certification and Recertification Timeframes. (1) The KHBE will take final action on the request for certification or recertification of QHPs no later than August 31 for the following plan year.

(2) A QHP not certified or recertified by August 31 may not be offered on the exchange at any time during the following calendar year.

Section 5. Transparency in Coverage. (1) A QHP issuer shall provide the following information to the office in accordance with the standards established by subsection (2) of this section:

(a) Claims payment policies and practices;

(b) Periodic financial disclosures;

(c) Data on enrollment;

(d) Data on disenrollment;

(e) Data on the number of denied claims;

(f) Data on rating practices;

(g) SBC;

(h) Information on cost-sharing and payments for out-of-network coverage; and

(i) Information on enrollee rights under Title I of the Affordable Care Act.

(2) A QHP issuer shall:

(a) Submit, in an accurate and timely manner, to be determined by HHS, the information described in subsection (1) of this section to the KHBE, HHS, and DOI; and

(b) Provide public access to the information described in subsection (1) of this section.

(3) A QHP issuer shall ensure that the information submitted under subsection (1) of this section is provided in plain language as the term is defined by 45 C.F.R. 155.20.

(4)(a) A QHP issuer shall make available, in a timely manner, information about the amount of enrollee cost-sharing under the enrollee's plan or coverage relating to provision of a specific item or service by a participating provider upon the request of the enrollee.

(b) The information shall be made available to an enrollee through:

1. An Internet Web site; and

2. Other means if the enrollee does not have access to the Internet.

Section 6. Marketing and Benefit Design of QHPs. A QHP issuer and its officials, employees, agents, and representatives shall:

(1) Comply with issuer marketing practices provided under KRS 304.17A and 806 KAR 12:010; and

(2) Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with complex health care needs in QHPs.

Section 7. Network Adequacy Standards. (1) A QHP issuer shall ensure that the provider network of a QHP is available to all enrollees within the QHP service area, and:

(a) Includes essential community providers in the QHP provider network in accordance with 45 C.F.R. 156.235 and meets the network adequacy standards for essential community providers as established in Section 8 of this administrative regulation;

(b) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be provided in a timely manner; and

(c) Meets the reasonable network adequacy provisions of 45 C.F.R. 156.230 and KRS 304.17A-515.

(2) A QHP issuer shall make its provider directory for a QHP available:

(a) To the KHBE for online publication;

(b) To potential enrollees in hard copy upon request; and

(c) In accordance with KRS 304.17A-590.

(3) A QHP issuer shall identify in the QHP provider directory a provider that is not accepting new patients.

Section 8. Network Adequacy Standards for Essential Community Providers for Coverage Year 2014. A QHP issuer shall:

(1)(a) Demonstrate a provider network, which includes at least twenty (20) percent of available essential community providers in the QHP service area participate in the issuers provider network; and

(b) Offer a contract to:

1. At least one (1) essential community provider in each essential community provider category in each county in the service area where an essential community provider in that category is available; and

2. Available Indian providers in the service area, using the Model Indian Addendum as developed by The Centers for Medicare and Medicaid Services and identified in the "Supplementary Response: Inclusion of Essential Community Providers" form incorporated by reference in this administrative regulation; or

(2) If unable to comply with the requirements in subsection (1) of this section:

(a) Demonstrate a provider network which includes at least ten (10) percent of available essential community providers in the QHP service area; and

(b) Submit a supplementary response as identified in "Supplementary Response: Inclusion of Essential Community Providers" as incorporated by reference in this administrative regulation.

Section 9. Health Plan Applications and Notices. A QHP issuer shall provide an application, including the streamlined application designated by the office, and notices to enrollees pursuant to standards described in 45 C.F.R. 155.230.

Section 10. Consistency of Premium Rates Inside and Outside the KHBE for the Same QHP. A QHP issuer shall charge the same premium rate without regard to whether the plan is offered:

(1) Through the KHBE;

(2) By an issuer outside the KHBE; or

(3) Through a participating agent.

Section 11. Enrollment Periods for Qualified Individuals. (1) A QHP issuer participating in the individual market shall:

(a) Enroll a qualified individual during the initial and annual open enrollment periods described in 45 C.F.R 155.410(b) and (e) and comply with the effective dates of coverage established by the KHBE in accordance with 45 C.F.R. 155.410(c)(1) and (f); and

(b) Make available, at a minimum, special enrollment periods described in 45 C.F.R. 155.420(d), for QHPs and comply with the effective dates of coverage established by the KHBE in accordance with 45 C.F.R 155.420(b).

(2) A QHP issuer shall notify a qualified individual of the effective date of coverage.

(3) Notwithstanding the requirements of this section, coverage shall not be effective until premium payment is submitted by the individual.

Section 12. Enrollment Process for Qualified Individuals. (1) A QHP issuer shall process enrollment of an individual in accordance with this section.

(2) A QHP issuer participating in the individual market shall enroll a qualified individual if the KHBE:

(a) Notifies the QHP issuer that the individual is a qualified individual; and

(b) Transmits information to the QHP issuer in accordance with 45 C.F.R. 155.400(a).

(3) If an applicant initiates enrollment directly with the QHP issuer for enrollment in a plan offered through the KHBE, the QHP issuer shall either:

(a) Direct the individual to file an application with the KHBE in accordance with 45 C.F.R. 155.310; or

(b) Ensure the applicant received an eligibility determination for coverage through the KHBE through the KHBE Internet Web site.

(4) A QHP issuer shall accept enrollment information in accordance with the privacy and security requirements established by the KHBE pursuant to 45 C.F.R. 155.260 and in an electronic format pursuant to with 45 C.F.R. 155.270.

(5) A QHP issuer shall follow the premium payment process established by the KHBE in accordance with 45 C.F.R. 155.240.

(6) A QHP issuer shall provide new enrollees with an enrollment information package that complies with the accessibility and readability requirements established by 45 C.F.R. 155.230(b).

(7) A QHP issuer shall reconcile enrollment files with the KHBE no less than once a month in accordance with 45 C.F.R. 155.400(d).

(8) A QHP issuer shall acknowledge receipt of enrollment information transmitted from the KHBE in accordance with KHBE requirements established by 45 C.F.R. 155.400(b)(2).

Section 13. Termination of Coverage for Qualified Individuals. (1) A QHP issuer may terminate coverage of an enrollee in accordance with 45 C.F.R. 155.430(b)(2).

(2) If an enrollee's coverage in a QHP is terminated for any reason, the QHP issuer shall:

(a) Provide the enrollee with a notice of termination of coverage that includes the reason for termination at least thirty (30) days prior to the final day of coverage, in accordance with the effective date established pursuant to 45 C.F.R. 155.430(d);

(b) Notify the KHBE of the termination effective date and reason for termination; and

(c) Comply with the requirements of KRS 304.17A-240 to 304.17A-245.

(3) Termination of coverage of enrollees due to non-payment of premium in accordance with 45 C.F.R. 155.430(b)(2)(ii) shall:

(a) Include the grace period for enrollees receiving advance payments of the premium tax credits as described in 45 C.F.R.

156.270 (d); and

(b) Be applied uniformly to enrollees in similar circumstances.

(4) A QHP issuer shall provide a grace period of three (3) consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one (1) full month's premium during the benefit year. During the grace period, the QHP issuer:

(a) 1. Shall pay claims for services provided to the enrollee in the first month of the grace period; and

2. May suspend payment of claims for services provided to the enrollee in the second and third months of the grace period;

(b) Shall notify HHS of the non-payment of the premium due; and

(c) Shall notify providers of the possibility for denied claims for services provided to an enrollee in the second and third months of the grace period.

(5) For the three (3) months grace period described in subsection (4) of this section, a QHP issuer shall:

(a) Continue to collect advance payments of the premium tax credit on behalf of the enrollee from the U.S. Department of the Treasury; and

(b) Return advance payments of the premium tax credit paid on behalf of the enrollee for the second and third months of the grace period if the enrollee exhausts the grace period as described in subsection (7) of this section.

(6) If an enrollee is delinquent on premium payment, the QHP issuer shall provide the enrollee with a notice of the payment delinquency.

(7) If an enrollee receiving advance payments of the premium tax credit exhausts the three (3) months grace period in subsection (4) of this section without paying the outstanding premiums, the QHP issuer shall terminate the enrollee's coverage on the effective date of termination described in 45 C.F.R. 155.430(d)(4) if the QHP issuer meets the notice requirement specified in subsection (2) of this section.

(8) A QHP issuer shall maintain records in accordance with KHBE requirements established pursuant to 45 C.F.R. 155.430(c).

(9) A QHP issuer shall comply with the termination of coverage effective dates as described in 45 C.F.R. 155.430(d).

Section 14. Accreditation of QHP Issuers. (1) A QHP issuer shall:

(a) Be accredited on the basis of local performance of a QHP by an accrediting entity recognized by HHS in categories identified by 45 C.F.R. 156.275(a)(1); and

(b) Pursuant to 45 C.F.R. 156.275(a)(2) authorize the accrediting entity that accredits the QHP issuer to release to the KHBE and HHS:

1. A copy of the most recent accreditation survey; and

2. Accreditation survey-related information that HHS may require, including corrective action plans and summaries of findings.

(2) A QHP issuer shall be accredited within three (3) years of initial QHP certification in accordance with requirements identified by 45 C.F.R. 155.1045.

(3) The QHP issuer shall maintain accreditation so long as the QHP issuer offers QHPs.

Section 15. Recertification, Non-renewal, and Decertification of QHPs. (1) A QHP shall be recertified in accordance with the requirements of this administrative regulation every two (2) years no later than August 31 for the following plan year.

(2) An issuer shall submit to the exchange a request for recertification of a QHP at least ninety (90) days prior to an expiration of a certification.

(3) If a QHP issuer elects not to seek recertification with the KHBE, the QHP issuer, at a minimum, shall:

(a) Notify the KHBE of its decision prior to the beginning of the recertification process and follow the procedures adopted by the KHBE in accordance with 45 C.F.R. 155.1075;

(b) Provide benefits for enrollees through the final day of the plan or benefit year;

(c) Submit reports as required by the KHBE for the final plan or benefit year of the certification;

(d) Provide notices to enrollees in accordance with Section 13 of this administrative regulation;

(e) Terminate coverage of enrollees in the QHP in accordance with 45 C.F.R. 156.270, as applicable; and

(f) Comply with requirements of KRS 304.17A-240 and 304.17A-245.

(4) If a QHP is decertified by the KHBE pursuant to 45 C.F.R. 155.1080, the QHP issuer shall terminate coverage of enrollees only after:

(a) The KHBE has provided notification as required by 45 C.F.R 155.1080(e);

(b) Enrollees have an opportunity to enroll in other coverage; and

(c) The QHP issuer has complied with the requirements of KRS 304.17A-240 and 304.17A-245.

Section 16. General Requirements for a Stand-alone Dental Plan. (1) In order for a dental insurer to participate in the KHBE beginning January 1, 2014 and offer a stand-alone dental plan, the dental insurer shall:

(a) Hold a certificate of authority to offer dental plans and be in good standing with the Kentucky Department of Insurance;

(b) Be authorized by the office to participate on the KHBE;

(c) Enter into a participation agreement with the KHBE;

(d) Offer a pediatric dental plan certified by the KHBE in accordance with this administrative regulation in the individual exchange or SHOP exchange that shall:

1. Comply with the requirements of KRS Chapter 304 Subtitle17C;

2. Submit to DOI through the SERFF system:

a. Form and rate filings in compliance with KRS Chapter 304; and

b. Dental plan management data templates;

(e) Offer a stand-alone dental plan that shall:

1. Be limited to a pediatric dental essential health benefit required by 42 U.S.C. 18022(b)(J) for individuals up to twenty-one (21) years of age;

2. Pursuant to 45 C.F.R. 156.150, provide within a variation of plus or minus two (2) percentage points:

a. A low level of coverage with an actuarial value of seventy (70) percent; and

b. A high level of coverage with an actuarial value of eighty five (85) percent; and

3. Have an annual limitation on cost-sharing at or below:

a. $1,000 for a plan with one (1) child enrollee; or

b. $2,000 for a plan with two (2) or more child enrollees;

(f) Comply with the:

1. Provider network adequacy requirements identified by KRS 304.17C-040 and maintain a network that is sufficient in number and types of dental providers to assure that all dental services will be accessible without unreasonable delay in accordance with 45 C.F.R. 156.230;

2. Requirements for stand-alone dental plans referenced in 45 C.F.R. 156 Subpart E; and

3. Essential community provider requirement in 45 C.F.R. 156.235; and

(g) Not discriminate, with respect to a pediatric dental plan, on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

(2) The dental insurer offering a stand-alone dental plan participating in the KHBE beginning January 1, 2014:

(a) May offer a stand-alone dental plan which includes coverage for individuals regardless of age which includes at a minimum a pediatric dental essential health benefit required by 42 U.S.C. 18022(b)(J) coverage for individuals up to twenty-one (21) years of age; and

(b) If electing to offer the plan specified in paragraph (a) of this subsection, shall comply with the requirements of subsection (1) of this section.

Section 17. Essential health benefits for individuals up to twenty-one (21) years of age. The KHBE shall ensure that an individual up to age twenty-one (21) years of age eligible to enroll in a QHP shall obtain coverage for pediatric dental coverage.

Section 18. Enforcement. The DOI shall be responsible for enforcing the requirements of KRS Chapter 304 and any administrative regulations promulgated thereunder against any issuer.

Section 19. Issuer Appeals. (1) An issuer may appeal the office's decision to:

(a) Deny certification of a QHP;

(b) Deny recertification of a QHP; or

(c) Decertify a QHP.

(2) An issuer appeal identified in subsection (1) of this section shall be made to the office in accordance with KRS Chapter 13B.

Section 20. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Chapter 7: Instructions for the Essential Community Providers Application Section", April 2013 version; and

(b) "Supplementary Response: Inclusion of Essential Community Providers", April 2013 version.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of the Kentucky Health Benefit Exchange, 12 Mill Creek Park, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or from its Web site at www.healthbenefitexchange.ky.gov.

CARRIE BANAHAN, Executive Director
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: May 10, 2013

FILED WITH LRC: May 13, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 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 June 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 administra-tive 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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: Carrie Banahan

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the criteria for certification as a qualified health plan or a qualified dental plan to be offered on the Kentucky Health Benefit Exchange as required by 45 C.F.R. Parts 155 and 156.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to inform issuers of the requirements for certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary so that issuers are aware of the requirements for certification of a health plan as a qualified health plan or dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange as required by 45 C.F.R. Parts 155 and 156.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed requirements for certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange to comply with the 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 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 governments affected by this administrative regulation: This administrative regulation will affect approximately 15 issuers that may request certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange.

(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 submit information electronically through the SERFF system related to rate and form filings to the Department of Insurance for review by DOI and KHBE.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): $1,000.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This administrative regulation will benefit each issuer that may request certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit by providing detailed instructions regarding certification of Qualified Health Plans.

(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.

(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 Kentucky Office of Health Benefit Exchange 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 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 the Kentucky Health Benefit Exchange 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 194A.050(1), 42 U.S.C. § 18031, and 45 C.F.R. Parts 155 and 156.

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:

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. Section 18031 and 45 C.F.R. Parts 155 and 156.

2. State compliance standards. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet, and to implement programs mandated by federal law or to qualify for the receipt of federal funds. This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan to be offered on the Kentucky Health Benefit Exchange, pursuant to, and in accordance with 42 U.S.C. Section 18031 and 45 C.F.R. Parts 155 and 156.

3. Minimum or uniform standards contained in the federal mandate. The Affordable Care Act establishes the creation of the American Health Benefit Exchange as identified in Section 1311(a) of the Affordable Care Act. The "Kentucky Health Benefit Exchange" (KHBE) is the Kentucky state-based exchange conditionally approved by HHS established by 45 C.F.R. 155.105 to offer a QHP in Kentucky beginning January 1, 2014. An Exchange must make qualified health plans available to qualified individuals and qualified employers. At a minimum, an Exchange must implement procedures for the certification, recertification, and decertification of health plans as qualified health plans. The Affordable Care Act allows for Exchanges to certify health plans as qualified health plans. This certification may be done if: the health plan meets the rules for certification by the U. S. Department of Health and Human Services; and the Exchange determines that making such health plan available through the Exchange is in the interests of qualified individuals and qualified employers in the state or states in which the Exchange operates. The Exchange must require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. These plans must prominently post such information on their websites.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose stricter requirements than those required by the federal mandate.

STATEMENT OF EMERGENCY
907 KAR 3:225E

This emergency administrative regulation is being promulgated to establish Medicaid policies regarding specialty intermediate care (IC) clinic services. Specialty intermediate care clinics will provide an array of outpatient services - including medical, behavioral, psychiatric, nutritional, and therapy services - which will be individualized to meet the treatment needs of Medicaid recipients in the community who have a mental illness, intellectual disability, or developmental disability and meet the qualifying criteria. Specialty intermediate care clinics will also provide outpatient services to residents of intermediate care facilities for individuals with an intellectual disability. This action must be taken on an emergency basis in accordance with KRS 13A.190(1)(a) to comply with the terms of a legal settlement between the Cabinet for Health and Family Services and the United States Department of Justice and to prevent a loss of federal funds. Failure to enact this administrative regulation on an emergency basis in accordance with KRS 13A.190(1)(a) will compromise the Cabinet's ability to comply with the terms of the Strategic Action Plan incorporated into the Commonwealth's Settlement Agreement with the U.S. Department of Justice's Civil Rights Division and to prevent a loss of federal funds. The Strategic Action Plan calls for the establishment of specialty intermediate care clinics on the grounds of state-owned intermediate care facilities for individuals with an intellectual disability as a means of serving individuals in the most integrated setting appropriate to their needs. 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.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Healthcare Facilities Management
(New Emergency Administrative Regulation)

907 KAR 3:225E. Specialty intermediate care (IC) clinic service and coverage policies and requirements.

RELATES TO: KRS 205.520(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), and 205.520(3)

EFFECTIVE: May 8, 2013

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 any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes Medicaid program service and coverage policies and requirements regarding specialty intermediate care clinic services.

Section 1. Definitions. (1) "1915(c) home and community based services waiver program" means a Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c).

(2) "Audiologist" is defined by KRS 334A.020(5).

(3) "Behavior Analyst Certification Board" means the nonprofit corporation:

(a) Established in 1998; and

(b) Known as the Behavior Analyst Certification Board®, Inc.

(4) "Board certified behavior analyst" means an individual who is currently certified by the Behavior Analyst Certification Board as a certified behavior analyst.

(5) "Clinical laboratory" means a medical laboratory pursuant to KRS 333.020(3).

(6) "Department" means the Department for Medicaid Services

or its designee.

(7) "Developmental disability" means a severe chronic disability which:

(a) Is attributable to a mental or physical impairment or combination of mental and physical impairments manifested before the person attains the age of twenty-two (22);

(b) Is likely to continue indefinitely;

(c) Results in substantial limitations in three (3) or more areas of major life activity including:

1. Self-care;

2. Receptive and expressive language;

3. Learning;

4. Self direction;

5. Mobility; and

6. Capacity for independent living and economic sufficiency; and

(d) Requires individually planned and coordinated services of a lifelong or extended duration.

(8) "Enrollee" means an individual who is enrolled with a managed care organization for the purposes of receiving Medicaid program or KCHIP program covered services.

(9) "Epileptologist" means a physician who specializes in treating patients who have epilepsy.

(10) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(11) "Functional assessment" means an assessment performed using evidenced-based tools, direct observation, and empirical measurement to obtain and identify functional relations between behavioral and environmental factors.

(12) "Licensed psychological associate" means an individual who is currently licensed in accordance with KRS 319.064.

(13) "Licensed psychological practitioner" means an individual who is currently licensed in accordance with KRS 319.053.

(14) "Licensed psychologist" means an individual who is currently licensed in accordance with KRS 319.050.

(15) "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.

(16) "Medically necessary" means determined by the department to be needed in accordance with 907 KAR 3:130.

(17) "Neurologist" means a physician who specializes in neurology.

(18) "Occupational therapist" is defined by KRS 319A.010(3).

(19) "Occupational therapist assistant" is defined by KRS 319A.010(4).

(20) "Ophthalmic dispenser" means an individual licensed to perform ophthalmic dispensing in accordance with KRS 326.030.

(21) "Ophthalmic dispensing" is defined by KRS 326.010(2).

(22) "Physical therapist" is defined by KRS 327.010(2).

(23) "Physical therapist assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy and related duties as assigned by the supervising physical therapist.

(24) "Physical therapy" is defined by KRS 327.010(1).

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

(26) "Physician services" means the practice of medicine or osteopathy provided by a physician.

(27) "Positive behavior support specialist" means an individual who:

(a) Provides:

1. Evidence-based individual interventions that assist a recipient with acquiring or maintaining skills for community living; and

2. Behavioral intervention to reduce maladaptive behaviors;

(b) Has a master's degree in a behavioral science and one (1) year of experience in behavioral programming; and

(c) Has at least one (1) year of direct services with individuals with an intellectual or developmental disability.

(28) "Practice of medicine or osteopathy" is defined by KRS 311.550(11).

(29) "Practice of psychology" is defined by KRS 319.010(6).

(30) "Primary care provider" means:

(a) A licensed primary care physician who is a:

1. Doctor of medicine or osteopathy; and

2. General practitioner, family practitioner, pediatrician, internist, obstetrician, or gynecologist;

(b) A licensed, certified advanced practice registered nurse who:

1. Has a "Collaborative Practice Agreement for Prescriptive Authority" in accordance with KRS 314.042; and

2. Has a signed written agreement with a primary care physician for backup twenty-four (24) hours per day seven (7) days a week for needed prescriptions and other primary care services outside the scope of practice of the advanced practice registered nurse;

(c) A physician group practice which bills the department using a group practice Medicaid provider number;

(d) A licensed primary care center operating under physician supervision which has at least one (1) full-time equivalent primary care physician who is a general practitioner, family practitioner, doctor of osteopathy, pediatrician, internist, obstetrician, or gynecologist;

(e) A licensed rural health clinic operating under physician supervision by a primary care physician who is a general practitioner, family practitioner, doctor of osteopathy, pediatrician, internist, obstetrician, or gynecologist; or

(f) A licensed physician specialist who is a doctor of medicine or osteopathy if the specialist agrees to serve as a primary care provider.

(31) "Psychiatrist" is defined by KRS 504.060(8).

(32) "Psychological services" means the practice of psychology.

(33) "Psychotropic medication" means a medication that is:

(a) Prescribed to treat the symptoms of a psychiatric disorder; or

(b) Utilized emergently to address psychiatric symptoms.

(34) "Recipient" is defined by KRS 205.8451(9).

(35) "Rural health clinic" is defined by 42 C.F.R. 405.2401(b).

(36) "Specialty intermediate care clinic" or "specialty IC clinic" means a clinic licensed pursuant to 902 KAR 20:410.

(37) "Speech-language pathologist" is defined by KRS 334A.020(3).

Section 2. Conditions of Participation. A specialty intermediate care clinic service shall be provided by an individual:

(1) Employed by a specialty intermediate care clinic; or

(2) Working for a specialty intermediate care clinic via a contractual agreement.

Section 3. Eligible Population. (1) To be eligible to receive specialty IC clinic services, an individual shall:

(a) Be a recipient:

(b) Have a mental illness, intellectual disability, or developmental disability; and

(c) Meet the patient status criteria established in:

1. Section 4(4) of 907 KAR 1:022; or

2. Section 4(5) of 907 KAR 1:022.

(2)(a) A recipient shall be eligible to receive services stated in Section 6 of this administrative regulation and in accordance with the requirements established in Section 6 of this administrative regulation if the recipient is:

1. Eligible in accordance with subsection (1) of this section;

2. Not receiving services via:

a. A 1915(c) home and community services waiver program; or

b. An intermediate care facility for individuals with an intellectual disability; and

3. Enrolled with a managed care organization.

(b) A recipient shall be eligible to receive services stated in Section 5 of this administrative regulation and in accordance with the requirements established in Section 5 of this administrative regulation if the recipient is:

1. Eligible in accordance with subsection (1) of this section;

2. Receiving services via:

a. A 1915(c) home and community services waiver program; or

b. An intermediate care facility for individuals with an intellectual disability; and

3. Not enrolled with a managed care organization.

Section 4. General Requirements Regarding Services. (1)(a) The department shall:

1. Reimburse for a specialty IC clinic service if the service was:

a. Medically necessary; and

b. Provided:

(i) By a specialty IC clinic; and

(ii) To an individual who is eligible to receive specialty IC clinic services pursuant to Section 3(1) and (2)(b) of this administrative regulation; or

2. Not reimburse for a specialty intermediate care clinic service if the service does not:

a. Meet the criteria established in paragraph (a) of this subsection; or

b. Comply with subsection (2) of this section.

(b) A managed care organization shall:

1. Reimburse for a specialty IC clinic service if the service was:

a. Medically necessary; and

b. Provided:

(i) By a specialty IC clinic; and

(ii) To an individual who is eligible to receive specialty IC clinic services pursuant to Section 3(1) and (2)(a) of this administrative regulation; or

2. Not reimburse for a specialty intermediate care clinic service if the service does not:

a. Meet the criteria established in paragraph (a) of this subsection; or

b. Comply with subsection (2) of this section.

(2) Services provided at a specialty IC clinic shall comply with the requirements established in 42 C.F.R. 440.90.

Section 5. Specialty Intermediate Care Clinic Services for Recipients Who are Not Enrolled with a Managed Care Organization. The following shall be the covered specialty intermediate care clinic services for an individual who is not enrolled with a managed care organization and who is eligible in accordance with Section 3(1) and (2)(b) of this administrative regulation:

(1) Dental services provided:

(a) By an authorized practitioner in accordance with 907 1:026; and

(b) In accordance with the limits established in 907 KAR 1:026;

(2) Psychiatric services provided:

(a) By a:

1. Psychiatrist; or

2. Physician; and

(b) In accordance with the psychiatric service limit established in 907 KAR 3:005;

(3) Psychological services provided by a licensed psychologist, licensed psychological practitioner, or licensed psychological associate;

(4) Psychotropic medication management provided by an advanced practice registered nurse, physician, or psychiatrist;

(5) Neurology services provided by a neurologist;

(6) Epileptology services provided by an epileptologist;

(7) Preventive health care;

(8) Primary and sub-specialist medical assessment and treatment;

(9) Occupational therapy provided:

(a) By an occupational therapist or occupational therapist assistant; and

(b) In accordance with the limits and requirements established in Section 6 of this administrative regulation;

(10) Physical therapy provided:

(a) By a physical therapist or physical therapist assistant; and

(b) In accordance with the limits and requirements established in Section 6 of this administrative regulation;

(11) Speech therapy provided:

(a) By a speech-language pathologist; and

(b) In accordance with the limits and requirements established in Section 6 of this administrative regulation;

(12) Nutritional or dietary consultation;

(13) Mobility evaluation or treatment;

(14) Positive behavioral support services which shall:

(a) Be the systematic application of techniques and methods to influence or change a behavior in a desired way;

(b) Be provided to assist a recipient to learn a new behavior that is directly related to existing challenging behaviors or a functionally equivalent replacement behavior for identified challenging behaviors;

(c) Include a functional assessment of the recipient's behavior which shall include:

1. An analysis of the potential communicative intent of the behavior;

2. The history of reinforcement for the behavior;

3. The critical variables that preceded the behavior;

4. The effects of different situations on the behavior;

5. A hypothesis regarding the motivation, purpose, and factors which maintain the behavior;

(d) Include the development of a positive behavioral support plan which shall:

1. Be developed by a behavioral support specialist:

2. Be implemented by staff in all relevant environments and activities;

3. Be revised as necessary at least once every six (6) months;

4. Define the techniques and procedures used;

5. Be designed to equip the recipient to communicate his or her needs and to participate in age-appropriate activities;

6. Include the hierarchy of behavior interventions ranging from the least to the most restrictive;

7. Reflect the use of positive behavioral approaches; and

8. Prohibit the use of prone or supine restraint, corporal punishment, seclusion, verbal abuse, or any procedure which denies private communication, requisite sleep, shelter, bedding, food, drink, or use of a bathroom facility;

(e) Include the provision of competency-based training to other providers concerning implementation of the positive behavioral support plan;

(f) Include the monitoring of a recipient's progress which shall be accomplished through:

1. The analysis of data concerning the frequency, intensity, and duration of behavior; and

2. The reports of a provider involved in implementing the positive behavioral support plan;

(g) Provide for the design, implementation, and evaluation of systematic environmental modifications;

(h) Be provided by a behavioral support specialist; and

(i) Be documented by a detailed staff note which shall include:

1. The date of the service;

2. The beginning and end time;

3. The signature, date of signature, and title of the behavior support specialist;

(15) Audiology provided by an audiologist and in accordance with the following:

(a) The limits established in 907 KAR 1:038 for services provided to an individual under the age of twenty-one (21) years shall be the limits for audiology services provided in a specialty intermediate care clinic regardless of the recipient's age; and

(b) The restriction established in 907 KAR 1:038 of not covering audiology services for an individual who is at least twenty-one (21) years of age shall not apply to audiology services provided in a specialty intermediate care clinic;

(16) Ophthalmic dispensing provided by an ophthalmic dispenser;

(17) A prescribed drug covered in accordance with 907 KAR 1:019;

(18) Medication consultation;

(19) Medication management;

(20) Seizure management;

(21) Diagnostic services;

(22) Clinical laboratory services;

(23) Physician services in accordance with the limits and requirements established in
907 KAR 3:005; or

(24) Laboratory services in accordance with the limits and requirements established in 907 KAR 1:028.

Section 6. Specialty Intermediate Care Clinic Services for Recipients Who are Enrolled with a Managed Care Organization. The following shall be the covered specialty intermediate care clinic

services for an individual who is enrolled with a managed care organization and who is eligible in accordance with Section 3(1) and (2)(a) of this administrative regulation:

(1) Dental services provided in accordance with 907 KAR 1:026 except that a dentist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(2) Physicians services provided in accordance with 907 KAR 3:005 except that:

(a) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(3) Psychiatric services provided in accordance with 907 KAR 3:005 except that:

(a) A psychiatrist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(b) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(c) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(4) Behavioral health services in accordance with:

(a) 907 KAR 1:054 except that:

1. A clinical psychologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

2. An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(b) 907 KAR 1:082 except that:

1. A clinical psychologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

2. An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(c) 907 KAR 1:044 except:

1. That:

a. A clinical psychologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

b. A psychiatrist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

c. An advanced practice registered nurse who is certified in the practice of mental health nursing, meets the requirements of 201 KAR 20:057, and who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; and

2. For the following which shall not be covered if provided by a specialty IC clinic:

a. Inpatient services;

b. Therapeutic rehabilitation services for adults;

c. Therapeutic rehabilitation services for children; or

d. Services in a detoxification setting;

(5) Audiology services provided in accordance with 907 KAR 1:038 except that an audiologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(6) Ophthalmic dispensing provided by an ophthalmic dispenser in accordance with 907 KAR 1:038 except that an ophthalmologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(7) A prescribed drug covered in accordance with 907 KAR 1:019 except that a pharmacist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(8) Preventive health care in accordance with 907 KAR 3:005 except that:

(a) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(9) Occupational therapy in accordance with 907 KAR 3:005 except that an:

(a) Occupational therapist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) Occupational therapy assistant who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(10) Physical therapy in accordance with 907 KAR 3:005 except that a:

(a) Physical therapist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) Physical therapist assistant who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(11) Speech therapy in accordance with 907 KAR 3:005 except that a speech language pathologist who is an employee of or under contract with a specialty IC clinic shall be authorized to provide the services;

(12) Diagnostic services in accordance with 907 KAR 1:014, 907 KAR 1:054, 907 KAR 1:082, or 907 KAR 3:005 except that:

(a) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(13) Laboratory services in accordance with 907 KAR 1:028 except that if a specialty IC clinic's laboratory does not meet the requirements of 907 KAR 1:028, the specialty IC clinic shall be authorized to provide the services via a contractual relationship with a laboratory which meets the requirements of 907 KAR 1:028.

Section 7. Therapy Limits. (1) To be reimbursable by the department, occupational therapy, physical therapy, or speech therapy shall be limited to thirty (30) visits per twelve (12) months for a recipient except as established in subsection (1) of this section.

(2) The therapy limits established in subsection (1) of this section shall:

(a) Not apply to a recipient under twenty-one (21) years of age; and

(b) Be overridden by the department if the department determines that an additional visit or visits beyond the limit are medically necessary.

Section 8. No Duplication of Service. (1) The department shall reimburse no more than one (1) provider for the provision of a given service to a recipient on a given day.

(2) There shall be no duplicate billing to the department regarding a given service provided to a recipient on a given day.

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 federal financial participation for the policy; or

(2) Disapproves the policy.

Section 10. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: April 15, 2013

FILED WITH LRC: May 8, 2013 at 10 a.m.

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@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 Medicaid specialty intermediate care (IC) clinic service and coverage policies and requirements.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid policies and requirements for specialty IC clinic services related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate-care facilities for individuals with an intellectual disability (ICF-IID) as a means of serving individuals in the most integrated setting appropriate to their needs.

(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 policies and requirements for specialty IC clinic services.

(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 establishing Medicaid policies and requirements for specialty IC clinic services.

(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: Affected individuals include Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability but who may be able to transition to a community setting as a result of this administrative regulation; individuals who are participating in a 1915(c) home and community based waiver program; and individuals who are neither of the aforementioned two (2) populations but are enrolled with a managed care organization. Additionally, the clinics themselves will be affected. One (1) facility, located in Louisville, has already been constructed and the start of construction for another facility, in Somerset, Kentucky, is anticipated to begin in June 2013.

(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: If a given specialty IC clinic wishes to be reimbursed by Medicaid for services provided to Medicaid recipients, the clinic will have to comply with the service requirements, practitioner requirements (including practitioner qualifications), and be licensed as a specialty IC clinic.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability; are receiving services via a 1915(c) home and community based waiver program; or are neither of the two (2) aforementioned but are enrolled with a managed care organization would benefit by being able to receive these outpatient clinic services.

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

(a) Initially: The Department for Medicaid Services estimates that implementing this administrative regulation will cost DMS $600,000 per month (state and federal combined) for each month of implementation in state fiscal year 2013.

(b) On a continuing basis: DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

(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 the Social Security Act, Title XIX and matching funds from state general 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 increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the regulated entities are regulated uniformly by this 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 impacted by this administrative regulation? The Department for Medicaid Services (DMS) and the Department for Behavioral Health, Developmental and Intellectual Disabilities 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. 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? DMS projects no revenue will be generated by the administrative regulation.

(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? DMS projects no revenue will be generated by the administrative regulation.

(c) How much will it cost to administer this program for the first year? DMS estimates that implementing this administrative regulation will cost DMS $600,000 per month (state and federal combined) for each month of implementation in state fiscal year 2013.

(d) How much will it cost to administer this program for subsequent years? DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

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. The mandate source is a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic ac-

tion plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate-care facilities for individuals with an intellectual disability as a means of serving individuals in the most integrated setting appropriate to their needs.

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. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate-care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

STATEMENT OF EMERGENCY
907 KAR 3:230E

This emergency administrative regulation is being promulgated to establish Medicaid reimbursement policies and requirements regarding specialty intermediate care (IC) clinic services. Specialty intermediate care clinics will provide an array of outpatient services - including medical, behavioral, psychiatric, nutritional, and therapy services - which will be individualized to meet the treatment needs of Medicaid recipients in the community who have a mental illness, intellectual disability, or developmental disability and meet the qualifying criteria. Specialty intermediate care clinics will also provide outpatient services to residents of intermediate care facilities for individuals with an intellectual disability. This action must be taken on an emergency basis in accordance with KRS 13A.190(1)(a) to comply with the terms of a legal settlement between the Cabinet for Health and Family Services and the United States Department of Justice and to prevent a loss of federal funds. Failure to enact this administrative regulation on an emergency basis in accordance with KRS 13A.190(1)(a) will compromise the Cabinet's ability to comply with the terms of the Strategic Action Plan incorporated into the Commonwealth's Settlement Agreement with the U.S. Department of Justice's Civil Rights Division and to prevent a loss of federal funds. The Strategic Action Plan calls for the establishment of specialty intermediate care clinics on the grounds of state-owned intermediate care facilities for individuals with an intellectual disability as a means of serving individuals in the most integrated setting appropriate to their needs. 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.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Healthcare Facilities Management
(New Emergency Administrative Regulation)

907 KAR 3:230E. Reimbursement policies and requirements for specialty intermediate care (IC) clinic services.

RELATES TO: KRS 216B.450 through 459, 42 C.F.R. Part 413, 42 C.F.R. 447.204, 42 C.F.R. 447.321

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), and 205.560(2)

EFFECTIVE: May 8, 2013

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 any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the reimbursement policies and requirements for covered specialty intermediate care clinic services provided to a Medicaid recipient who is not enrolled with a managed care organization and optional policies for covered specialty IC clinic services provided to a Medicaid recipient who is enrolled with a managed care organization.

Section 1. Definitions. (1) "Bad debt" means accounts receivable which will likely remain uncollected.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(4) "Government Auditing Standards" means the standards:

(a) For audits of government organizations, programs, activities, functions, and of government assistance received by contractors, nonprofit organizations, and other nongovernment organizations;

(b) Often referred to as generally accepted government auditing standards or GAGAS; and

(c) Accessible at the Web site of http://www.gao.gov/govaud/ybk01.htm.

(5) "Medically necessary" means determined by the department to be needed in accordance with 907 KAR 3:130.

(6) "Recipient" is defined by KRS 205.8451(9).

(7) "Specialty intermediate care clinic" or "specialty IC clinic" means a clinic located on the grounds of a state-owned facility licensed pursuant to 902 KAR 20:086 as an intermediate care facility for individuals with an intellectual disability.

Section 2. Interim Reimbursement. (1)(a) Except for a specialty IC clinic's first fiscal year of operation, the department shall reimburse on an interim basis:

1. For specialty intermediate care clinic services via an interim rate and utilizing a clinic-specific cost-to-charge ratio:

a. For each service;

b. Based on the clinic's most recently filed cost report, unless no cost report exists; and

c. Expressed as a percent of the clinic's charges; and

2. During the course of a state fiscal year until the most recent full fiscal year cost report from the clinic has been finalized by the department.

(b) The department shall use projected costs to establish interim rates for the first fiscal year of a specialty IC clinic's operation.

(2) The department shall determine a:

(a) Clinic-specific cost-to-charge ratio for each service; and

(b) Specialty IC clinic's interim rate for a service by:

1. Multiplying the total charges for the service by the service-specific cost-to-charge ratio; and

2. Dividing the number established pursuant to subparagraph 1. of this paragraph by the applicable number of service units. For example, $500,000 in total charges multiplied by a cost-to-charge ratio of 0.95 divided by 10,000 units equals an interim rate of forty-seven (47) dollars and fifty (50) cents.

(3) An interim rate for a fiscal year shall be effective on July 1

of a calendar year and remain in effect until close of business June 30 of the subsequent calendar year.

(4)(a) The department shall adjust an interim rate if:

1. The department miscalculated a specialty IC clinic's interim rate;

2. A specialty IC clinic submits an amended cost report which applies to the interim rate period; or

3. A further desk or on-site audit of a cost report used to establish the interim rate discloses a change in allowable costs.

(b) The department shall not adjust an interim rate for a reason not described in paragraph (a)1, 2, or 3 of this subsection.

(5) The department shall use the most recently received ICF-IID and Specialty Intermediate Care Clinic Cost Report as of March 15 to establish interim rates for a specialty IC clinic to be effective on July 1 of a given year.

Section 3. Final Reimbursement. (1) After the most recent full fiscal year cost report for a specialty IC clinic has been finalized by the department, the department shall cost settle with the clinic to establish final reimbursement to the clinic for the corresponding fiscal year.

(2) A cost settlement between the department and a specialty IC clinic shall:

(a) Be limited to an amount, if any, by which the specialty IC clinic's allowable costs exceeds the amount of:

1. Any third party recovery during the fiscal year; and

2. Interim payments made to the specialty IC clinic; and

(b) Not exceed the federal upper payment limit in accordance with 42 C.F.R. 447.321.

(3)(a) The department's reimbursement to a specialty IC clinic shall be payment in full to the specialty IC clinic for services provided to recipients.

(b) A specialty IC clinic shall not bill a recipient for a service provided to a recipient.

(c) A bad debt shall not be:

1. An allowable cost; or

2. Reimbursable by the department.

Section 4. Cost Reporting Requirements. (1)(a) A specialty IC clinic shall annually submit to the department a fully completed ICF-IID and Specialty Intermediate Care Clinic Cost Report within four (4) calendar months of the end of the prior state fiscal year.

(b) For example, an ICF-IID and Specialty Intermediate Care Clinic Cost Report covering the fiscal year ending June 30, 2013 shall be submitted to the department by close of business October 31, 2013.

(2) A specialty IC clinic shall complete an ICF-IID and Specialty Intermediate Care Clinic Cost Report in accordance with the ICF-IID and Specialty Intermediate Care Clinic Cost Report Instructions.

(3) Interim reimbursement for a specialty IC clinic which does not submit a legible and complete ICF-IID and Specialty Intermediate Care Clinic Cost Report to the department within the time period referenced in subsection (1) of this section shall be placed in escrow by the department until the department receives a legible and completed ICF-IID and Specialty Intermediate Care Clinic Cost Report.

(4) After finalizing the first full fiscal year cost report submitted by a facility, the department shall establish an interim rate based on the first full year cost report.

(5)(a) An ICF-IID and Specialty Intermediate Care Clinic Cost Report shall include the statement stated in paragraph (b) of this subsection and the statement shall immediately precede the dated signature of the specialty IC clinic's administrator or chief financial officer.

(b) "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Kentucky Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were reported in compliance with such laws and regulations. This cost report includes total computable cost incurred to provide Medicaid services."

(6) If a cost report indicates a payment is due by a specialty IC clinic to the department, the specialty IC clinic shall submit the amount due or submit a payment plan request with the cost report.

(7) If a cost report indicates a payment is due by a specialty IC clinic to the department and the specialty IC clinic fails to remit the amount due or request a payment plan, the department shall suspend future payment to the specialty IC clinic until the specialty IC clinics remits the payment or submits a request for a payment plan.

(8)(a) If it is determined that an additional payment is due by a specialty IC clinic after a final determination of cost has been made by the department, the additional payment shall be due by the specialty IC clinic to the department within sixty (60) days after notification.

(b) If a specialty IC clinic does not submit the additional payment within sixty (60) days, the department shall withhold future payment to the specialty IC clinic until the department has collected in full the amount owed by the specialty IC clinic to the department.

(9)(a) A specialty IC clinic shall report all of its costs, allowable costs, and unallowable costs on a cost report.

(b) The department shall not reimburse for or cost settle unallowable costs.

Section 5. Allowable and Unallowable Costs. (1) An allowable cost shall:

(a) Be allowable in accordance with 42 C.F.R. Part 413;

(b) Be a cost allowed after an audit by the department; and

(c) Include:

1. A cost incurred by a specialty IC clinic in meeting and maintaining health standards pursuant to 42 C.F.R. 431.610(c); and

2. Costs resulting from meeting Kentucky specialty clinic licensure requirements pursuant to 902 KAR 20:410.

(2) Reimbursable services shall be the specialty IC clinic services established in 907 KAR 3:225.

(3) Costs relating to unallowable clinic activities shall:

(a) Be excluded from any cost settlement;

(b) Not be reimbursable; and

(c) Be reported separately on a cost report.

Section 6. Audits. (1) An ICF-IID and Specialty Intermediate Care Clinic Cost Report and all related documents submitted to the department by a specialty IC clinic shall be subject to audit, review, and reconciliation by the department.

(2) An audit, if performed, shall be performed in accordance with the most current Government Auditing Standards available via the Web site of http://www.gao.gov/govaud/ybk01.htm.

Section 7. Pharmacy, Medication, Immunization, and Other Costs Not Reimbursed at Cost. (1) The department shall reimburse for:

(a) Prescription drug costs experienced by a specialty IC clinic through the department's pharmacy program in accordance with 907 KAR 1:018; or

(b) Immunization costs experienced by a specialty IC clinic through the department's physicians' program in accordance with 907 KAR 3:010.

(2) Medication:

(a) Consultation costs shall be allowable; and

(b) Management costs shall be allowable.

Section 8. Not Applicable to Managed Care Organizations. (1) A managed care organization may elect to reimburse for specialty IC clinic services in accordance with this administrative regulation.

(2) The reimbursement policies established in this administrative regulation shall not apply to a managed care organization.

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 federal financial participation for the policy; or

(2) Disapproves the policy.

Section 10. Appeals. (1) An interim rate adjustment or denial of an interim rate adjustment may be appealed in accordance with 907 KAR 1:671.

(2) A Medicaid program sanction or appeal shall be in accor-

dance with 907 KAR 1:671.

Section 11. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "ICF-IID and Specialty IC Clinic Cost Report", March 2013 edition; and

(b) "ICF-IID and Specialty IC Clinic Cost Report Instructions", March 2013 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 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: April 15, 2013

FILED WITH LRC: May 8, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@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 Medicaid reimbursement policies and requirements for specialty intermediate care (IC) clinic services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

(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 reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights.

(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 reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights.

(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: Affected individuals include Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability but who may be able to transition to a community setting as a result of this administrative regulation. Additionally, any Medicaid recipients already living in a community setting and who need specialty IC clinic services could be affected. Lastly, the clinics themselves will be affected. One (1) facility, located in Louisville, has already been constructed and the start of construction for another facility, in Somerset, Kentucky, is anticipated to begin in June 2013.

(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: Specialty IC clinics will have to annually submit an ICF-IID and Specialty Intermediate Care Clinic Cost Report to DMS in order to be reimbursed for specialty IC clinic services provided to Medicaid recipients.

(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 the regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability but who may be able to transition to a community setting as a result of this administrative regulation would benefit. Additionally, any Medicaid recipients already living in a community setting and who need specialty IC clinic services could benefit by the expanded access to services.

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

(a) Initially: The Department for Medicaid Services estimates that implementing this administrative regulation will cost DMS $600,000 per month (state and federal combined) for each month of implementation in state fiscal year 2013.

(b) On a continuing basis: DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

(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 the Social Security Act, Title XIX and matching funds from state general 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 increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the regulated entities are regulated uniformly by this 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 impacted by this administrative regulation? The Department for

Medicaid Services and the Department for Behavioral Health, Developmental and Intellectual Disabilities 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. This administrative regulation is necessary to establish Medicaid reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

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? DMS projects no revenue to be generated by the administrative regulation.

(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? DMS projects no revenue to be generated by the administrative regulation.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services estimates that implementing this administrative regulation will cost DMS $600,000 (state and federal combined) for each month of implementation in state fiscal year 2013.

(d) How much will it cost to administer this program for subsequent years? DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

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. The mandate source is a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

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. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

ADMINISTRATIVE REGULATIONS AS AMENDED BY PROMULGATING AGENCY AND REVIEWING SUBCOMMITTEE

ARRS = Administrative Regulation Review Subcommittee
IJC = Interim Joint Committee

GOVERNOR'S OFFICE
Kentucky Department of Veterans' Affairs
Office of Kentucky Veterans' Centers
(As Amended at ARRS, May 14, 2013)

17 KAR 3:010. Calculation of resident charges at state veterans' nursing homes.

RELATES TO: KRS 40.320, 40.325
STATUTORY AUTHORITY: KRS 40.325(2)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 40.320 requires the Commonwealth[~~identifies the Commonwealth's duty~~] to provide for the well-being of elderly and disabled veterans within state veterans' nursing homes. KRS 40.325(2) authorizes the Department of Veterans' Affairs to promulgate any administrative regulations necessary to operate the homes in compliance with applicable state and federal statutes and regulations. This administrative regulation establishes the requirements for calculating resident charges for room and care services within the state veterans' nursing homes.

Section 1. Definitions. (1) "Ability to pay" means the total amount of available assets and available monthly income on the part of the resident and spouse.
(2) "Administrator" means the person in charge of a state veterans' nursing home, or that person's specific designee.
(3) "Assets" means the market value of items owned by the resident and spouse as applicable including:
(a) Stocks, bonds, and notes;
(b) Individual retirement accounts;
(c) Bank deposits;
(d) Savings accounts;
(e) Cash;
(f) Real estate;
(g) Cash value of life insurance policies; or
(h) Face value of prepaid burial plans.
(4) "Available assets" means the total assets of the resident and spouse less the applicable exclusions established[~~specified~~] in Section 2(5) of this administrative regulation.
(5) "Available monthly income" means the gross monthly income of the resident and spouse less the applicable exclusions established[~~specified~~] in Section 2(4) of this administrative regulation.
(6) "Community spouse" means the spouse of a resident who is not herself or himself a resident of a state veterans' nursing home.
(7) [~~"Department" means the Kentucky Department of Veterans' Affairs.~~
~~(8)~~] "Dependent" means an individual less than eighteen (18) years of age who is in the resident's care.
(8)[~~(9)~~] "Exclusions" means an amount deducted from a resident and spouse's gross monthly income and total assets to determine the ability to pay for services rendered by a nursing home.
(9)[~~(10)~~] "Gross monthly income" means the amount of income received by the resident and spouse on a monthly basis plus those amounts originally withheld from wages and earnings.
(10)[~~(11)~~] "Income" means funds received by the resident and spouse***, including[~~and shall include the following~~]***:
(a) VA, U.S. Civil Service, U.S. Railroad, Military, Social Security, and any other form of service-related compensation or[~~and~~] pension;
(b) Wages from all employers;
(c) Interest and dividends;
(d) Workers'[~~Workers~~] compensation; and
(e) Rental or other business income.
(11)[~~(12)~~] "Nursing home" means a state veterans' nursing home operated by the Kentucky Department of Veterans' Affairs.
(12)[~~(13)~~] "Resident" means a veteran admitted to a state veterans' nursing home.
(13)[~~(14)~~] "Spouse" means the wife or husband of a resident who is not divorced or legally separated from the veteran.
(14)[~~(15)~~] "Withholdings" means those dollar amounts originally deducted from monthly income, such as:
(a) Deductions for income taxes;
(b) Deductions for health and life insurance premiums; and
(c) Deductions for retirement plans.

Section 2. Determination of the Ability to Pay for Services Rendered at State Veterans' Nursing Homes. (1)(a) Except as provided in paragraph (b) of this subsection, the nursing home shall compute the ability to pay for each resident who is admitted to the facility for care in accordance with this administrative regulation.
(b) If the provisions of 17 KAR 3:040 are applicable to a resident, the nursing home shall compute the ability to pay for that resident in accordance with 17 KAR 3:040.
(2) The amount a resident is required to pay for services shall be the lesser of:
(a) The maximum charge established[~~specified~~] in 17 KAR 3:020; or
(b) The amount the resident is deemed able to pay in accordance with this administrative regulation.
(3) The nursing home shall determine an ability to pay amount for each resident based on the following factors:
(a) Available assets; and
(b) Available monthly income.
(4) The following shall be authorized exclusions from gross monthly income:
(a) Medicare B insurance premium (resident only);
(b) Health insurance premium (resident only), not to exceed $150 per month;
(c) A resident's personal needs allowance of $150 per month;
(d) A maintenance allowance for a community spouse of $1,500 per month;
(e) A maintenance allowance of $400 per month for each dependent;
(f) Court-ordered support payments to an ex-spouse, not to exceed $400 per month; or
(g) Court ordered support payments for a child less than eighteen (18) years of age, not to exceed $400 per child per month.
(5) The following shall be authorized exclusions from assets:
(a) Primary residence (including any contiguous land);
(b) A resident burial exclusion consisting of cash, life insurance policy, or prepaid burial plan with a combined value of $10,000 or less;
(c) A spousal exclusion consisting of an allocation of assets totaling $100,000 (or a lesser amount if sufficient assets are not available) on the date the resident is admitted;
(d) All household equipment and personal effects owned by the resident and spouse;
(e) One (1) automobile; and
(f) Any outstanding debts on the day of admission to the nursing home.
(6) If it is determined that a resident disposed of a nonexcluded asset by gift, or for an amount less than fair market value, during the two (2) year period preceding the date of admission, the monthly charge for room and care shall be computed as if the resident retained ownership of the asset as of the date of admission.
(7) The monthly spousal allowance and dependent's allowance shall be utilized by the resident to help meet the financial needs of his or her spouse or dependent. If the facility becomes aware that these allowances are not being utilized for their intended purpose, the resident's monthly charge for room and care shall be recalculated as if the resident were unmarried and without dependents.

(8) If a married couple is admitted to a nursing home, the monthly charge shall be computed as if each resident were unmarried and without dependents.

(a) All assets and debts of the residents shall be allocated at a rate of fifty (50) percent to each individual.

(b) All income earned by the couple shall be considered to be earned at a rate of fifty (50) percent to each.

(c) Only one (1) primary residence and one (1) automobile shall be excluded for purposes of computing available assets for the couple.

Section 3. Calculation of the Amount Resident is Able to Pay. (1) The nursing home shall calculate the ability to pay amount utilizing the ["]Ability to Pay Worksheet, OKVC Form #2["].

(a) The Ability to Pay Worksheet, OKVC Form #2,[~~form~~] shall be explained to the resident or person responsible for the resident and signed by all parties.

(b) A copy of the Ability to Pay Worksheet, OKVC Form #2,[~~this form~~] shall be provided to the resident or person responsible for the resident.

(2) The amount of available assets shall be determined as follows:

(a) Calculate the total amount of assets owned by the resident and spouse;

(b) Apply the exclusions established[~~identified~~] in Section 2(5) of this administrative regulation; and

(c) The remaining assets shall equal the available assets.

(3) The amount of available monthly income shall be determined as follows:

(a) Determine the amount of total monthly income for the resident and spouse;

(b) Identify all withholdings and add that total to total monthly income to determine gross monthly income;

(c) Apply the exclusions established[~~identified~~] in Section 2(4) of this administrative regulation to the gross monthly income total; and

(d) The remaining income shall equal the available monthly income.

(4) The resident's monthly charge for room and care shall be computed as follows:

(a) Add the available assets to the available monthly income to determine the ability to pay amount;[~~:~~]

(b) If the ability to pay amount is between zero dollars[~~$0~~] and the facility's maximum charge, the resident's monthly charge shall equal the ability to pay amount; and

(c) If the ability to pay amount is equal to or greater than the facility's maximum charge, the resident's monthly charge shall equal the facility's maximum charge.

(5) After the resident's ability to pay is determined, a ["]Patient or Responsible Party Financial Agreement, OKVC Form #3,[~~" form~~] shall be completed.

(a) The Patient or Responsible Party Financial Agreement, OKVC Form #3,[~~form~~] shall be explained to the resident and signed by all parties.

(b) If the resident or person responsible for the resident refuses to sign, this refusal shall be noted on the Patient or Responsible Party Financial Agreement, OKVC Form #3,[~~form~~] including the date the form was discussed.

(c) Refusal to sign the Patient or Responsible Party Financial Agreement, OKVC Form #3,[~~form~~] shall result in the resident paying the maximum charge for room and care.

Section 4. Revisions to Ability to Pay Amounts. (1) Nursing home staff shall update a resident's ability to pay amount to incorporate changes that take place subsequent to the initial determination. These changes[~~may~~] include, for example:

(a) Income revisions;

(b) Asset revisions including exhaustion of available assets;

(c) Changes in allowed exclusions; and[~~or~~]

(d) Identification of previously undisclosed income or assets.

(2) Upon a change in the ability to pay information, a revised ["]Ability to Pay Worksheet, OKVC Form #2,["] shall be prepared along with a revised ["]Patient or Responsible Party Financial Agreement, OKVC Form #3["~~ form~~]. The revised forms shall be presented to the resident in the same manner as the original forms.

Section 5. Failure to Provide Financial Information or to Assign Benefits. (1) Failure of the resident to disclose financial information required to compute his or her ability to pay shall result in the resident paying the maximum charge for room and care.

(2) If the resident or person responsible for the resident fails to sign the assignment provision contained in the ["]Patient or Responsible Party Financial Agreement, OKVC Form #3["~~ form~~], the maximum charge for room and care shall be assessed.

Section 6. Payment Hardship and Appeal Procedures. (1) Payment hardships.

(a) If the resident or person responsible for the resident believes that the ability to pay amount will result in a financial hardship, the resident or responsible person may request to make installment payments.

(b) This request shall be made in writing to the nursing home's administrator and shall include documentation to support the claimed hardship.

(c) The administrator shall review the financial hardship request and render a payment plan decision within fifteen (15) days from the receipt of the hardship request.

(2) Appeals.

(a) If the resident or person responsible for the resident is aggrieved by the facility charges or a payment plan determined in accordance with this administrative regulation, the resident or person responsible for the resident may appeal the determination to the Executive Director, Office of Kentucky Veterans' Centers, 1111 Louisville Road, Frankfort, Kentucky 40601. An appeal shall be submitted[~~40621,~~] within thirty (30) days of the ability to pay or payment plan being calculated.

(b) The executive director shall review the appeal and issue a determination within fifteen (15) days of receipt.

(c) If the resident or person responsible for the resident is dissatisfied with the informal resolution, the resident or person responsible for the resident may file an appeal. An appeal shall be submitted within thirty (30) days of the executive director's response to the Commissioner, Kentucky Department of Veterans Affairs, 1111 Louisville Road, Frankfort, Kentucky 40601[~~40621~~]. If the commissioner is unable to resolve the appeal request informally, he shall arrange for an administrative hearing in accordance with KRS Chapter 13B.

(d) The appeal request shall fully explain the resident's or responsible person's position and include all necessary supporting documentation.

Section 7. Incorporation by Reference. (1) The following material is incorporated by reference:

(a)[~~OKVC Form #2,~~] "Ability to Pay Worksheet", OKVC Form #2, [~~(~~October 10, 2006[~~)~~]; and

(b)[~~OKVC Form #3,~~] "Patient or Responsible Party Financial Agreement", OKVC Form #3, ***April 2013***[~~(~~***[October 12, 2006]***[~~)~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Veterans Affairs, 1111B Louisville Road, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

KENNETH R. LUCAS, Commissioner

APPROVED BY AGENCY: February 6, 2013

FILED WITH LRC: February 6, 2013 at 4 p.m.

CONTACT PERSON: Gilda Hill, Executive Director, 1111B Louisville Road, Frankfort, Kentucky 40601, phone (502)564-9203, fax (502)564-9240.

GENERAL GOVERNMENT CABINET
Kentucky Board of Pharmacy
(As Amended at ARRS, May 14, 2013)

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: ***315.002, 315.005,*** KRS 315.191(1)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 315.191(1) ***authorizes[~~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. **Definitions.** (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 **centralized automated** pharmacy **system[~~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 ***pursuant to[~~under~~]*** 902 KAR 20:016 or a pharmacy serving an other[~~another~~] 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)[~~(2)~~] "Investigational drug" means ***a drug that[~~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)[~~(3)~~] "Other organized health care facility" means a facility:
(a) ***With a primary purpose[~~Whose primary purpose is~~]*** to provide medical care and treatment to inpatients; and
(b) That is:
1. An intermediate care facility;
2. A skilled nursing facility;
3. A hospital other than an acute care hospital licensed ***pursuant to[~~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
9. An Alzheimer's nursing home.
(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 ***the doses[~~they~~]*** are needed.

Section 2. Pharmacy Administration. (1) General.
(a) The pharmacy, organized as a separate department or service, shall be directed by a ***[~~professionally competent, legally qualified~~]***pharmacist***, who shall be thoroughly knowledgeable about institutional pharmacy practice and management***.
(b) 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 ***and shall be responsible to the chief executive officer of the institution or the chief executive officer's designee***.
(c)[~~(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 ***a[~~an appropriately qualified~~]*** pharmacist to provide services required by this administrative regulation and KRS 315.020(1).
(d)[~~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.
(2)[~~(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, ***nonpharmacist personnel[~~they~~]*** shall perform all duties under the supervision of a pharmacist and ***[~~they~~]***shall not be assigned ***and shall not perform[~~, nor shall they perform,~~]*** duties that are to be performed only by a pharmacist[~~pharmacists~~].
(3)[~~(4)~~] Responsibilities.
(a)***1.*** Lines of authority and areas of responsibility within the pharmacy shall be clearly defined.
2. Written job descriptions for all categories of pharmacy personnel shall be prepared and revised as necessary.
(b)***1.*** 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.
2. Provision for procurement of drugs in an emergency situation shall be provided for.
(4)[~~(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.
(5)[~~(6)~~] Availability.
(a) The services of a pharmacist shall be available ***continuously.[~~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 ***(1)*** 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 key~~] by authorized pharmacy personnel only.
(3)(a) 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.
(b) A currently licensed hospital exempt from the provisions of subsection (2) of this section shall permit access by authorized personnel only.
(4) Location. Locked storage or locked medication carts shall be provided for use in each nursing unit or service area.
(5) Reference materials. The pharmacy shall have current pharmaceutical reference materials in accordance with 201 KAR 2:090. References related to the following subjects shall also be available:
(a) Drug identification;
(b) Toxicology;
(c) Drug interactions;

(d) Parenteral drug compatibility; and
(e) Microbiology.

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. Policies and procedures governing these functions shall be developed by the pharmacist with input from other involved hospital or other organized health care facility staff (***for example[~~e.g.~~]***, nurses) and committees (***for example[~~e.g.~~]***, pharmacy and therapeutics committee and patient care committee).

(2) Dispensing. The pharmacist shall dispense medications only on the order of a licensed ***medical*** 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[~~situations~~].

(6) Labeling and packaging.

(a) Each licensee[~~All licensees~~] 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.

(a) Drugs shall be administered only upon order of a licensed ***medical*** practitioner.

(b) 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[~~regarding~~] and shall include personnel authorized to schedule, prepare, and administer medications.

(10)***(a)*** Unused medication. The institutional pharmacy shall establish policies and procedures for the disposition of patients' unused medications.

(b) Medication in unit dose form may be reissued if package integrity has been maintained and the product ***has not expired[~~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 (***for example[~~e.g.~~]***, emergency room, surgery, critical care, or medical or surgical wards).

(d) All drug storage areas within the hospital shall be routinely inspected by pharmacy personnel at least monthly***, and documentation shall be maintained to ensure that:***

1. Unusable items shall not be present; and

2. All stock items shall be[~~and documentation maintained to insure 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 ***a drug that has been recalled[~~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 date), 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 ***[~~his~~]***daily 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 ***ensure[~~insure~~]*** 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; and

(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 ***an[~~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 basis and annual review of the quality assurance program;

(5) Establishing policies and procedures if there is a system failure of ***an[~~any~~]*** automated pharmacy system;

(6) Providing the board with prior written notice of installation or removal of ***an[~~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 system 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 subsections (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 into the **centralized automated** pharmacy **system[~~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 ***a hospital licensed pursuant to[~~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 certified pharmacy technician.

(6) A record of medications stocked in an automated pharmacy system shall be maintained for ***at least*** 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 repackaging 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 processes established pursuant to Section 4(10) of this administrative regulation.

(12) A medication distributed by the **centralized automated** pharmacy **system[~~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

APPROVED BY AGENCY: March 27, 2013

FILED WITH LRC: April 15, 2013 at noon

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.

GENERAL GOVERNMENT CABINET
Board of Nursing
(As Amended at ARRS, May 14, 2013)

201 KAR 20:059. Advanced practice registered nurse controlled substances prescriptions.

RELATES TO: KRS 314.011(8)(c)

STATUTORY AUTHORITY: KRS ***314.011(8)(c),*** 314.131(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.011(8)(c) authorizes the Controlled Substances Formulary Development Committee to make recommendations to the Board of Nursing concerning any limitations for ***the prescription of*** specific controlled substances ***by advanced practice registered nurses***. This administrative regulation ***establishes limitations for the prescription of specific controlled substances by advanced practice registered nurses[~~implements that provision~~]***.

Section 1. Specific Controlled Substances. The following controlled substances have been identified as having the greatest potential for abuse or diversion:

(1) Diazepam (Valium), a Schedule IV medication;

(2) Clonazepam (Klonopin), a Schedule IV medication;

(3) Lorazepam (Ativan), a Schedule IV medication;

(4) Alprazolam (Xanax), a Schedule IV medication; and

(5) Carisoprodol (Soma), a Schedule IV medication[~~;~~

~~(6) Combination Hydrocodone products in liquid or solid dosage form, Schedule III medications~~].

Section 2. Limitations. Prescriptions for the medications listed in Section 1 of this administrative regulation shall be limited to a thirty (30) day supply without any refills.

SALLY BAXTER, President

APPROVED BY AGENCY: February 15, 2013

FILED WITH LRC: February 26, 2013 at 3 p.m.

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.

GENERAL GOVERNMENT CABINET
Board of Nursing
(As Amended at ARRS, May 14, 2013)

201 KAR 20:500. Nurse licensure compact.

RELATES TO: KRS 314.470
STATUTORY AUTHORITY: KRS 314.131
NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.470 adopted the Nurse Licensure Compact. The compact requires the adoption of this administrative regulation.

Section 1. Definitions. (1) "Board" means the party state's regulatory body responsible for issuing nurse licenses.
(2) "Information system" means the coordinated licensure information system.
(3) "Primary state of residence" means the state of a person's declared fixed permanent and principal home for legal purposes or domicile.
(4) "Public" means any individual or entity other than designated staff or representatives of party state boards or the National Council of State Boards of Nursing, Inc.

Section 2. Issuance of a License By a Compact Party State. (1) Effective June 1, 2007, an applicant for initial licensure shall not be issued a compact license granting a multistate privilege to practice, unless the applicant first obtains a passing score on the applicable NCLEX examination or any predecessor examination used for licensure.
(2) A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. That evidence shall include a declaration signed by the licensee. The applicant shall also furnish one (1) of the following:
(a) Driver's license with a home address;
(b) Voter registration card displaying a home address;
(c) Federal income tax return declaring the primary state of residence***;[.]***
(d) Military form no. 2058 - state of legal residence certificate; or
(e) W2 from the U.S. government or any bureau, division or agency thereof indicating the declared state of residence.
(3) A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residence. If the foreign country is declared the primary state of residence, a single state license shall be issued by the party state.
(4) A license issued by a party state is valid for practice in all other party states unless clearly designated as valid only in the state which issued the license.
(5) If a party state issues a license authorizing practice only in that state and not authorizing practice in other party states (i.e. a single state license), the license shall be clearly marked with words indicating that it is valid only in the state of issuance.
(6) A nurse changing primary state of residence, from one (1) party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed ninety (90)[~~thirty (30)~~] days.
(7) The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the ninety (90)[~~thirty (30)~~] day period in subsection (6)[~~(3)~~] of this section shall be stayed until resolution of the pending investigation.
(8) The former home state license shall no longer be valid upon the issuance of a new home state license.
(9) If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten (10) business days, and the former home state may take action in accordance with that state's laws and rules.

Section 3. Limitations on Multistate Licensure Privilege - Discipline. (1) Home state boards shall include in all licensure disciplinary orders or agreements that limit practice or require monitoring the requirement that the licensee subject to ***the[~~said~~]*** order or agreement shall agree to limit the licensee's practice to the home state during the pendency of the disciplinary order or agreement.
(2) This requirement may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and any other party state boards.
(3) An individual who had a license which was surrendered, revoked, suspended, or an application denied for cause in a prior state of primary residence may be issued a single state license in a new primary state of residence until ***the[~~such~~]*** time***[~~as~~]*** the individual would be eligible for an unrestricted license by the prior state of adverse action. Once eligible for licensure in the prior state, a multistate license may be issued.

Section 4. Information System. (1) Levels of access.
(a) The public shall have access to nurse licensure information limited to:
1. The nurse's name;
2. Jurisdiction or jurisdictions of licensure;
3. License expiration date or dates;
4. Licensure classifications and statuses held;
5. Public emergency and final disciplinary actions, as defined by contributing state authority; and
6. The status of multistate licensure privileges.
(b) Nonparty state boards shall have access to all information system data except current significant investigative information and other information as limited by contributing party state authority.
(c) Party state boards shall have access to all information system data contributed by the party states and other information as limited by contributing nonparty state authority.
(2) The licensee may request in writing to the home state board to review the data relating to the licensee in the information system. ***If[~~In the event~~]*** a licensee asserts that any data relating to him or her is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates that claim. The board shall verify and within ten (10) business days correct inaccurate data to the information system.
(3) The board shall report to the information system within ten (10) business days:
(a) Disciplinary action, agreement**,** or order requiring participation in alternative programs or which limit practice or require monitoring, except agreements and orders relating to participation in alternative programs required to remain nonpublic by contributing state authority;
(b) Dismissal of complaint; and
(c) Changes in status of disciplinary action or licensure encumbrance.
(4) Current significant investigative information shall be deleted from the information system within ten (10) business days upon report of disciplinary action, agreement**,** or order requiring participation in alternative programs or agreements which limit practice or require monitoring or dismissal of a complaint.
(5) Changes to licensure information in the information system shall be completed within ten (10) business days upon notification by a board.

SALLY BAXTER, President
APPROVED BY AGENCY: February 15, 2013
FILED WITH LRC: February 26, 2013 at 3 p.m.
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.

JUSTICE AND PUBLIC SAFETY CABINET
Department of Corrections
(As Amended at ARRS, May 14, 2013)

501 KAR 6:070. Kentucky Correctional Institution for Women.

RELATES TO: KRS Chapters 196, 197, 439
STATUTORY AUTHORITY: KRS 196.035, 197.020, 439.470, 439.590, 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 any division therein. 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 Correctional Institution for Women.

Section 1. Incorporation by Reference. (1) "Kentucky Correctional Institution for Women Policies and Procedures," ***May 14[February 14]***, 2013[April 14, 2008], are incorporated by reference. Kentucky Correctional Institution for Women Policies and Procedures include:
KCIW 01-03-01 Communications Between Staff and Inmates (Amended 2/14/13[2/15/08])
KCIW 01-08-01 News Media Access (Amended 2/14/13[4/14/08])
KCIW 02-04-01 Accounting Procedures (Amended 2/14/13[2/15/08])
KCIW 02-05-01 Inmate Canteen and Staff Canteen (Amended 2/14/13[2/15/08])
[KCIW 02-06-01 Interest Bearing Account (Amended 2/15/08)]
KCIW 05-01-01 Outside Consultation, Research and Student Interns[Research and Evaluation] (Amended 2/14/13[6/10/03])
[KCIW 05-02-01 Management Information System (Amended 6/10/03)
KCIW 05-03-01 Outside Consultation, Research, and Student Interns (Amended 6/10/03)]
KCIW 06-01-01 Offender Information[Inmate Records] (Amended ***5/14/13[2/14/13]***[Totally Revised 3/13/03])
[KCIW 06-01-03 Storage of Expunged Records (Totally Revised 3/13/03)]
KCIW 08-02-01 Fire Safety Practices (Amended 2/14/13[4/14/08])
KCIW 08-02-02 Fire Evacuation Routes (Amended 2/14/13[2/15/08])
KCIW 09-01-02 Inmate Move Sheet (Amended 2/14/13[Added 3/13/03])
KCIW 09-06-04 Regulation of Inmate Movement (Amended 2/14/13[Added 3/13/03])
KCIW 09-10-01 Pedestrian and Vehicular Traffic (Added 2/14/13)
KCIW 09-10-02 Inmate Entry and Exit Procedure (Amended ***5/14/13[2/14/13]***[Added 3/13/03])
KCIW 09-11-01 Prohibiting Inmate Authority Over Other Inmates (Amended 2/14/13[Added 3/13/03])
KCIW 09-12-01 Search Plan (Amended 2/14/13[Added 3/13/03])
KCIW 09-13-01 Tobacco Free Environment (Amended 2/14/13[7/9/07])
KCIW 09-13-02 Alcohol Detection (Amended ***5/14/13[2/14/13]***[Added 3/13/03])
KCIW 10-01-01 Special Management Unit General Operations and Regulations (Amended ***5/14/13[2/14/13]***[6/10/03])
KCIW 10-01-02 Special Management Unit Status[Programs], Placement and Review (Amended 2/14/13 [6/10/03])
KCIW 10-01-04 Death Row[Special Security] (Amended 2/14/13[Totally Revised 3/13/03])
[KCIW 11-01-01 Food Service Operation Inspections (Totally Revised 3/13/03)
KCIW 11-01-02 Budgeting, Accounting, and Purchasing for Food Service (Totally Revised 3/13/03)]
KCIW 11-02-01 Menu Preparation and Special Diets (Amended 2/14/13[Totally Revised 3/13/03])
KCIW 11-03-01[General Guidelines for] Food Service Operations (Amended 2/14/13[6/10/03])
KCIW 11-04-01 Health Regulations and General Guidelines for the Food Service Area (Amended 2/14/13[Totally Revised 3/13/03])
KCIW 11-07-01 Special Religious Diets (Amended 2/14/13[Totally Revised 3/13/03])
KCIW 12-01-01 Laundry, Clothing, and Personal Hygiene (Amended 2/14/13[Added 3/13/03])
KCIW 12-02-01 Pest Control (Amended 2/14/13[Added 3/13/03])
[KCIW 12-03-01 Water Supply and Waste Disposal (Added 3/13/03)]
KCIW 12-04-04 Sanitation Plan (Amended 2/14/13[Added 3/13/03])
KCIW 13-01-01 Provision of Medical and Dental Care (Amended ***5/14/13[2/14/13]***[10/11/05])
KCIW 13-01-02 Health Appraisal and Periodic Exams (Amended 2/14/13[10/11/05])
KCIW 13-01-03 Pharmaceutical Services (Amended 2/14/13[10/11/05])
KCIW 13-02-01 Family Notification (Amended ***5/14/13[2/14/13]***[10/11/05])
KCIW 13-03-01 Emergency Care (Amended 2/14/13[10/11/05])
KCIW 13-03-02 Convalescent and Chronic Care (Amended 2/14/13[10/11/05])
KCIW 13-04-02 Psychiatric and Psychological Services (Amended 2/14/13[10/11/05])
KCIW 13-07-01 Detoxification and Alcohol or Chemical Dependency (Amended 2/14/13[10/11/05])
KCIW 13-09-01 Suicide Prevention and Intervention Program (Amended 2/14/13[10/11/05])
KCIW 13-09-02 Inmate Observer Program (Amended 2/14/13[Added 4/14/08])
KCIW 13-13-01 Health Care[Healthcare] Records (Amended ***5/14/13[2/14/13]***[10/11/05])
KCIW 13-14-01 Health Services (Amended 2/14/13[10/11/05])
KCIW 13-14-02 Operational Guidelines for the Mental Health Area of the Lonnie Watson Center (Added 2/14/13)
KCIW 13-14-04 Injury Prevention (Added 2/14/13)
[KCIW 14-01-02 Inmate Rights (Totally Revised 3/13/03)]
KCIW 14-02-01 Access to Legal Resources and Services (Amended 2/14/13[Totally Revised 3/13/03])
[KCIW 14-04-01 Inmate Grievance Procedure (Totally Revised 3/13/03)]
KCIW 15-06-01 Restriction Guidelines (Amended 2/14/13[2/15/08])
KCIW 16-01-01 Inmate Correspondence (Amended 2/14/13[6/10/03])
KCIW 16-02-01 [Inmate] Access to Telephones (Amended 2/14/13[Totally Revised 3/13/03])
KCIW 16-03-01 Inmate Visiting [Regulations] (Amended ***5/14/13[2/14/13]***[Totally Revised 3/13/03])
KCIW 16-05-01 Inmate Packages (Amended 2/14/13[Totally Revised 3/13/03])
KCIW 17-01-01 Assessment Center Operations and Programs [and Classification Center Programs] (Amended ***5/14/13[2/14/13]***[Totally Revised 3/13/03])
KCIW 17-02-01 Admission Procedure (Amended 2/14/13[6/10/03])
KCIW 17-05-01 Inmate Personal Property (Amended ***5/14/13[2/14/13]***[Totally Revised 3/13/03])
KCIW 18-01-01 Inmate Classification (Amended 2/14/13[Added 3/13/03])
KCIW 18-01-03 Honor Program (Amended 2/14/13[4/14/08])
KCIW 18-05-01 Special Needs Inmates (Amended 2/14/13[Totally Revised 3/13/03])
KCIW 19-01-01 Inmate Work and Program Assignments (Amended 2/14/13[6/10/03])
KCIW 19-02-01 Governmental Services (Amended 2/14/13[Added 3/13/03])
KCIW 19-03-01 Landscape and Maintenance Work Details (Amended 2/14/13[Totally Revised 3/13/03])
KCIW 19-04-01 Correctional Industries (Amended 2/14/13[Added 3/13/03])
KCIW 20-01-01 Education Programs (Amended 2/14/13[Totally Revised 3/13/03])
KCIW 21-01-01 Library Services (Amended ***5/14/13[2/14/13]***[Added 3/13/03])

KCIW 22-01-01 Recreation and Inmate Activity (Amended 2/14/13[~~Added 3/13/03~~])
KCIW 22-01-02 Arts and Crafts Program (Amended 2/14/13[~~Added 3/13/03~~])
KCIW 22-01-04 Inmate Club Activities (Amended ***5/14/13[2/14/13]***[~~Totally Revised 3/13/03~~])
KCIW 23-01-01 Religious Services (Amended 2/14/13[~~Totally Revised 3/13/03~~])
[~~KCIW 23-01-02 Institutional Prayer (Added 3/13/03)~~]
KCIW 24-01-01 Social Services Program (Amended 2/14/13[~~Added 3/13/03~~])
KCIW 24-02-01 Substance Abuse Program (Amended 2/14/13[~~Added 3/13/03~~])
KCIW 25-02-01 Temporary Release and Community Release (Amended ***5/14/13[2/14/13]***[~~6/10/03~~])
KCIW 25-03-01 Funeral Home Visit or Bedside Visit (Amended 2/14/13[~~6/10/03~~])
KCIW 26-01-01 Volunteer Service Program (Amended 2/14/13[~~6/10/03~~])

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Justice and Public Safety Cabinet, Office of Legal Services, 125 Holmes Street, 2nd Floor, Frankfort, Kentucky 40601, phone (502) 564-3279, fax (502) 564-6686, Monday through Friday, 8 a.m. to 4:30 p.m.

LADONNA H. THOMPSON, Commissioner
APPROVED BY AGENCY: February 4, 2013
FILED WITH LRC: February 14, 2013 at 10 a.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.

JUSTICE AND PUBLIC SAFETY CABINET
Kentucky Law Enforcement Council
(As Amended at ARRS, May 14, 2013)

503 KAR 1:170. Career Development Program.

RELATES TO: KRS 15.310
STATUTORY AUTHORITY: KRS 15.330(1)(d), (h)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 15.330(1)(d) authorizes the Kentucky Law Enforcement Council (KLEC) to establish and prescribe minimum standards and qualifications for voluntary career development programs for certified peace officers and ***telecommunicators*** ***(***public safety dispatchers***)***. This administrative regulation establishes a Career Development Program for Kentucky certified peace officers and ***telecommunicators*** ***(***public safety dispatchers***)***.

Section 1. Definitions. (1) "Chief executive" means the highest level position in a law enforcement agency with direct operational and administrative responsibility for the policies and performance of the agency.
(2) "Conceptual skills course" means a course that emphasizes planning, organization, goal setting abilities, strategic orientation, or provides material related to higher order abstractions that force conceptual thinking.
(3) "Executive" means a position in the immediate line of authority under the chief executive who has the delegated responsibility for operational and administrative functions of the agency or division.
(4) "Human skills course" means a course relating to cultural diversity, problem solving, leadership, interpersonal communication, group communication, or training abilities.
(5) "KLEC" means the Kentucky Law Enforcement Council.
(6) "Manager" means a position within law enforcement or public safety dispatch[~~telecommunications~~]:
(a) Between the executive and supervisor positions; and
(b) Which is responsible for the supervision of supervisory employees, and possibly involving planning, organization, public relations, discipline, or general administrative work.
(7) ***"Public Safety Dispatch" means telecommunications as described in KRS 15.530-15.590.***
(8) "Public Safety Dispatcher" means a telecommunicator as described in KRS 15.530-15.590.
(9) "Supervisor" means a position which is responsible:
(a) For the direct supervision of nonsupervisory personnel; and
(b) Possibly for line duties in law enforcement or public safety dispatch[~~telecommunications~~].
(10)[(8)] "Technical skills course" means a course relating to operational or tactical abilities.

Section 2. Skill Area Determination. (1) Based on the definitions in Section 1 of this administrative regulation, the KLEC shall determine whether a law enforcement or public safety dispatch[~~telecommunications~~] course ***is[should be]*** categorized as a:
(a) Conceptual skills course;
(b) Human skills course; or
(c) Technical skills course.
(2) If a new course is approved or recognized by the KLEC, pursuant to 503 KAR 1:090 and 503 KAR 1:120, the council shall categorize the course in accordance with subsection (1) of this section.
(3) A law enforcement or public safety dispatch[~~telecommunications~~] course may be categorized in up to two (2) different categories.

Section 3. Application for Career Development Program. A peace officer or public safety dispatcher[~~telecommunicator~~] who wishes to apply for a particular career step certificate shall:
(1) Complete a "Form 1[~~CDP-1~~] Participant Commitment Form", which shall include the following:
(a) Applicant's name and agency;
(b) Social Security number and date of birth;
(c) Current rank and full time employee status;
(d) The program to which the applicant wishes to commit;
(e)[~~(d)~~] Signature of the applicant; and
(f)[~~(e)~~] Signature of the applicant's agency head;
(2) Submit one (1) of the following application forms for the specific career development step for which the participant wishes to apply:
(a) Intermediate Law Enforcement Officer;
(b) Advanced Law Enforcement Officer;
(c) Law Enforcement Officer Investigator;
(d) Law Enforcement Traffic Officer;
(e) Advanced Deputy Sheriff;
(f) Law Enforcement Supervisor;
(g) Law Enforcement Manager;
(h) Law Enforcement Executive;
(i) Intermediate Public Safety Dispatcher[~~Basic Telecommunicator~~];
(j) Advanced Public Safety Dispatcher[~~Intermediate Telecommunicator~~];
(k) Public Safety Dispatcher Supervisor[~~Advanced Telecommunicator~~];
(l) Public Safety Dispatcher[~~Telecommunications~~] Manager/Director;
(m) Law Enforcement Chief Executive[~~Training Officer~~];
(n) Law Enforcement Training Officer[~~Chief Executive~~];
(o) Law Enforcement Officer Advanced Investigator;
(p) Crime Scene Processing Officer;
(q) Communications Training Officer; or[~~Telecommunications Supervisor;~~]
(r) Crime Scene Technician[~~Communications Training Officer~~];
(3) Include the following information on the application form:
(a) Applicant's name and agency;
(b) Social Security number and date of birth;
(c) Date of employment with current agency;
(d) Current rank or title and date of promotion to that position;
(e) Employment history;
(f) Training history;
(g) Educational history;
(h) Signature of program applicant; and
(g) College and training credit hours applied to the requirements of the particular program to which the applicant wishes to apply; and

(4) Submit an official copy of a transcript or other documentation showing that the applicant has successfully completed ***the*** required:

(a) KLEC-approved or recognized courses; and

(b) College courses.

Section 4. In-service Training, College, Out-of-state Work Experience, Retroactive Credit. (1) The KLEC shall approve in-service training before it is applied toward a career development step.

(2) A program participant shall not receive more than one (1) program credit for an in-service training course.

(3) Retroactivity. Participants in the Career Development Program may be granted credit for college courses and KLEC-approved training received prior to the implementation of the program.

(4) Fifteen (15) hours of KLEC-approved classroom training may be substituted for one (1) hour of college credit by program participants.

(5) A program participant may apply out-of-state work experience toward the requirements of a career development step. To receive credit, the participant shall submit a written request describing the past experience and any supporting documentation to the KLEC for approval.

Section 5. Intermediate Law Enforcement Officer Certificate. To demonstrate proficiency in the Intermediate Law Enforcement Officer Career Step, a peace officer shall:

(1) Have active peace officer certification in accordance with KRS 15.386(2);

(2) Earn 160 additional hours of KLEC-approved or recognized in-service training, of which:

(a) Sixty (60) percent (ninety-six (96) hours) shall be in technical skills development; and

(b) Forty (40) percent (sixty-four (64) hours) shall be in human skills development; and

(3) Have one (1) of the following combinations of full-time law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Two (2) years of experience and a bachelor's degree;

(b) Four (4) years of experience and an associate's degree;

(c) Four (4) years of experience and ninety-five (95) hours of college credit;

(d) Five (5) years of experience and eighty (80) hours of college credit;

(e) Six (6) years of experience and sixty-five (65) hours of college credit;

(f) Seven (7) years of experience and fifty (50) hours of college credit; or

(g) Eight (8) years of experience and thirty-five (35) hours of college credit.

Section 6. Advanced Law Enforcement Officer Certificate. To demonstrate proficiency in the Advanced Law Enforcement Officer Career Step, a peace officer shall:

(1) Complete the Intermediate Law Enforcement Career Step;

(2) Earn 160 additional hours of KLEC-approved or recognized in-service training, of which:

(a) Forty (40) percent (sixty-four (64) hours) shall be in technical skills development;

(b) Forty (40) percent (sixty-four (64) hours) shall be in human skills development; and

(c) Twenty (20) percent (32 hours) shall be in conceptual skills development; and

(3) Have one (1) of the following combinations of full-time law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4) years of experience and a master's degree;

(b) Six (6) years of experience and a bachelor's degree;

(c) Eight (8)[~~Nine (9)~~] years of experience and an associate's degree;

(d) Eight (8) years of experience and 110 hours of college credit;

(e) Nine (9) years of experience and ninety-five (95) hours of college credit;

(f) Ten (10) years of experience and eighty (80) hours of college credit;

(g) Eleven (11) years of experience and sixty-five (65) hours of college credit; or

(h) Twelve (12) years of experience and fifty (50) hours of college credit.

Section 7. Law Enforcement Supervisor Certificate. To demonstrate proficiency in the Law Enforcement Supervisor Career Step, a peace officer shall:

(1) Have active peace officer certification in accordance with KRS 15.386(2);

(2) Earn a minimum of 160 additional hours of KLEC-approved or recognized in-service training as follows:

(a) Forty (40) hours of technical skills development courses;

(b) Forty (40) hours of conceptual skills development courses; and

(c) Eighty (80) hours in one (1) of the following options of courses:

1. Academy of Police Supervision;

2. The forty (40) hour basic supervisor's course and forty (40) hour advanced supervisor's course; or

3. A KLEC-approved or recognized equivalent course; and

(3) Have one (1) of the following combinations of full-time supervisory law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Two (2) years of experience and a master's degree;

(b) Four (4) years of experience and a bachelor's degree;

(c) Six (6) years of experience and an associate's degree;

(d) Six (6) years of experience and ninety-five (95) hours of college credit;

(e) Seven (7) years of experience and eighty (80) hours of college credit;

(f) Eight (8) years of experience and sixty-five (65) hours of college credit; or

(g) Nine (9) years of experience and fifty (50) hours of college credit.

Section 8. Law Enforcement Manager Certificate. To demonstrate proficiency in the Law Enforcement Manager Career Step, a peace officer shall:

(1) Have active peace officer certification in accordance with KRS 15.386(2);

(2) Complete the:

(a) Department of Criminal Justice Training Criminal Justice Executive Development Course;

(b) Department of Criminal Justice Training School for Strategic Leadership;

(c) Federal Bureau of Investigation (FBI) National Academy;

(d) University of Louisville Southern Police Institute Administrative Officers Course;

(e) Northwestern University School of Police Staff and Command;

(f) Police Executive Leadership College; or

(g) Another management[~~executive~~] leadership course recognized and approved by the KLEC as equal to one (1) of the above courses; and

(3) Have one (1) of the following combinations of full-time law enforcement management experience and credits from an accredited College or University, recognized by the Kentucky Council on Postsecondary Education:

(a) Two (2) years of experience and a master's degree;

(b) Four (4) years of experience and a bachelor's degree;

(c) Six (6) years of experience and an associate's degree;

(d) Six (6) years of experience and ninety-five (95) hours of college credit;

(e) Seven (7) years of experience and eighty (80) hours of college credit;

(f) Eight (8) years of experience and sixty-five (65) hours of college credit; or

(g) Nine (9) years of experience and fifty (50) hours of college credit.

Section 9. Law Enforcement Executive Certificate. (1) To demonstrate proficiency in the Law Enforcement Executive Career Step, a peace officer shall:

(a) Have active peace officer certification in accordance with KRS 15.386(2);

(b) Successfully complete:

1. Orientation for New Chiefs, offered by the Department of Criminal Justice Training;

2. Mandatory Duties of the Sheriff, offered by the Department of Criminal Justice Training;

3. Department of Criminal Justice Training School for Strategic Leadership;

4. Three (3) Police Executive Command courses, offered by the Department of Criminal Justice Training;

5. Three (3) Current Leadership Issues for Mid-level Executives (CLIMES) courses; or

6. Another executive leadership course recognized and approved by the KLEC as equal to one (1) of the courses listed ***in subparagraphs 1 through 5 of this paragraph[~~above~~]***[~~An executive level course as offered by the:~~

~~a. Federal Bureau of Investigation (FBI);~~

~~b. University of Louisville Southern Police Institute;~~

~~c. Northwestern University School of Police Staff and Command;~~

~~d. Institute of Police Technology and Management; or~~

~~e. Institute for Law Enforcement Administration~~];

(c) Successfully complete one (1) of the following:

1. 120 hours of training in conceptual or human skills development; or

2. Law Enforcement Management Career Step, plus forty (40) hours training in conceptual or human skills development; and

(d) Have one (1) of the following combinations of full-time executive law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

1. Two (2) years of experience and a bachelor's degree;

2. Three (3) years of experience and sixty (60) hours of college credit; or

3. Four (4) years of experience and thirty (30) hours of college credit.

(2) Points earned from in-service training courses shall not be used to substitute for college credit in the Law Enforcement Executive Career Step.

Section 10. Law Enforcement Chief Executive Certificate. (1) To demonstrate proficiency in the Law Enforcement Chief Executive Career Step, a peace officer shall:

(a) Successfully complete:

1. Orientation for New Chiefs, offered by the Department of Criminal Justice Training;

2. Mandatory Duties of the Sheriff, offered by the Department of Criminal Justice Training;

3. Department of Criminal Justice Training School for Strategic Leadership;

4. Three (3) Police Executive Command courses, offered by the Department of Criminal Justice Training;

5. Three (3) Current Leadership Issues for Mid-level Executives (CLIMES) courses; or

6. Another executive leadership course recognized by the KLEC as equal to one (1) of the ***[~~above~~]*** courses ***listed in subparagraphs 1 through 5 of this paragraph***[~~An executive level course as offered by the:~~

~~a. Federal Bureau of Investigation (FBI);~~

~~b. University of Louisville Southern Police Institute;~~

~~c. Northwestern University School of Police Staff and Command;~~

~~d. Institute of Police Technology and Management; or~~

~~e. Institute for Law Enforcement Administration~~];

(b) Successfully complete one (1) of the following:

1. 120 hours of training in conceptual or human skills development; or

2. Law Enforcement Management Career Step, plus forty (40) hours training in conceptual or human skills development; and

(c) Have one (1) of the following combinations of full-time executive law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

1. Two (2) years of experience and a bachelor's degree;

2. Three (3) years of experience and sixty (60) hours of college credit; or

3. Four (4) years of experience and thirty (30) hours of college credit.

(2) Points earned from in-service training courses shall not be used to substitute for college credit in the Law Enforcement Chief Executive Career Step.

Section 11. Law Enforcement Officer Investigator Certificate. To demonstrate proficiency in the Law Enforcement Investigator Career Step, a peace officer shall:

(1) Have active peace officer certification in accordance with KRS 15.386(2);

(2) Complete 200 hours of KLEC-approved or recognized in-service training, consisting of:

(a) Eighty (80) hour Criminal Investigations I course or KLEC-approved or recognized equivalent; and

(b) 120 training hours in investigative courses identified by the KLEC; and

(3) Have one (1) of the following combinations of full-time law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4) years of experience and a master's degree;

(b) Six (6) years of experience and a bachelor's degree;

(c) Eight (8)[~~Nine (9)~~] years of experience and an associate's degree;

(d) Eight (8) years of experience and 110 hours of college credit;

(e) Nine (9) years of experience and ninety-five (95) hours of college credit;

(f) Ten (10) years of experience and eighty (80) hours of college credit;

(g) Eleven (11) years of experience and sixty-five (65) hours of college credit; or

(h) Twelve (12) years of experience and fifty (50) hours of college credit.

Section 12. Law Enforcement Traffic Officer Certificate. To demonstrate proficiency in the Law Enforcement Traffic Career Step, a peace officer shall:

(1) Have active peace officer certification in accordance with KRS 15.386(2);

(2) Complete 200 hours of in-service training, consisting of:

(a) Forty (40) hour Collision Investigation Techniques[~~Eighty (80) hour basic accident investigation~~] course or a KLEC-approved equivalent; and

(b) 160[~~120~~] training hours in traffic courses identified by the KLEC; and

(3) Have one (1) of the following combinations of full-time law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4) years of experience and a master's degree;

(b) Six (6) years of experience and a bachelor's degree;

(c) Eight (8)[~~Nine (9)~~] years of experience and an associate's degree;

(d) Eight (8) years of experience and 110 hours of college credit;

(e) Nine (9) years of experience and ninety-five (95) hours of college credit;

(f) Ten (10) years of experience and eighty (80) hours of college credit;

(g) Eleven (11) years of experience and sixty-five (65) hours of college credit; or

(h) Twelve (12) years of experience and fifty (50) hours of college credit.

Section 13. Advanced Deputy Sheriff Certificate. To demonstrate proficiency in the Advanced Deputy Sheriff Career Step, a peace officer shall:

(1) Have active peace officer certification in accordance with KRS 15.386(2);

(2) Earn 160 additional hours of KLEC-approved or recognized in-service training, of which:

(a) Eighty (80) hours shall be in topics specific to sheriffs' responsibilities;

(b) Forty (40) hours shall be in technical skills development; and

(c) Forty (40) hours shall be in human skills development; and

(3) Have one (1) of the following combinations of full-time law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4)[~~Two (2)~~] years of experience and a master's[~~bachelor's~~] degree;

(b) Six (6)[~~Four (4)~~] years of experience and a[~~an~~] bachelor's[~~associate's~~] degree;

(c) Eight (8)[~~Four (4)~~] years of experience and an associate's degree[~~ninety-five (95) hours of college credit~~];

(d) Eight (8)[~~Five (5)~~] years of experience and 110[~~eighty (80)~~] hours of college credit;

(e) Nine (9)[~~Six (6)~~] years of experience and ninety-five (95)[~~sixty-five (65)~~] hours of college credit;

(f) Ten (10)[~~Seven (7)~~] years of experience and eighty (80)[~~fifty (50)~~] hours of college credit; [~~or~~]

(g) Eleven (11)[~~Eight (8)~~] years of experience and sixty-five (65)[~~thirty-five (35)~~] hours of college credit; or

(h) Twelve (12) years of experience and fifty (50) hours of college credit.

Section 14.[~~Basic Telecommunicator Certificate. To demonstrate proficiency in the Basic Telecommunications Career Step, a person shall:~~

~~(1) Have active certification as a:~~

~~(a) CJIS telecommunicator in accordance with KRS 15.565; or~~

~~(b) Non-CJIS telecommunicator in accordance with KRS 15.560; and~~

~~(2) Successfully complete the following courses:~~

~~(a) Twenty-four (24) hours of emergency medical dispatch;~~

~~(b) Forty (40) hours of basic telecommunications;~~

~~(c) Eight (8) hours of Crisis Negotiation;~~

~~(d) Eight (8) hours of family violence;~~

~~(e) Spanish for the Telecommunicator; and~~

~~(f) Incident command.~~

~~Section 15.~~] Communications Training Officer Certificate. To demonstrate proficiency in the Communications Training Officer Career Step, a person shall:

(1) Have active certification as a:

(a) CJIS telecommunicator in accordance with KRS 15.565; or

(b) Non-CJIS telecommunicator in accordance with KRS 15.560;

(2)[~~Complete the Basic Telecommunications Career Step;~~

~~(3)~~] Complete the following courses:

(a) Forty (40) hour Communications Training Officer course;

(b) Sixteen (16)[~~Eight (8)~~] hour Communications Training Officer: Developing a Training Program[~~professional development~~] course;

(c) Eight (8) hour Ethics course[~~Twenty-four (24) hours of elective courses from any telecommunications course approved by the KLEC, which shall include the sixteen (16) hour Communications Training Officer program if the course in paragraph (a) of this subsection is completed after January 1, 2011~~]; and

(d) A sixteen (16) hour Cultural Awareness course[~~An eight (8) hour KLEC-approved telecommunications ethics course, unless previously completed for Intermediate Telecommunicator certificate~~]; and

(3)[~~(4)~~] Have one (1) of the following combinations of full-time telecommunications experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4) years of experience and forty-five (45) hours of college credit;

(b) Five (5) years of experience and forty (40) hours of college credit;

(c) Six (6) years of experience and thirty-five (35) hours of college credit;

(d) Seven (7) years of experience and thirty (30) hours of college credit;

(e) Eight (8) years of experience and twenty-five (25) hours of college credit; or

(f) Nine (9) years of experience and twenty (20) hours of college credit.

Section 15[~~16~~]. Intermediate Public Safety Dispatcher[~~Telecommunicator~~] Certificate. To demonstrate proficiency in the Intermediate Public Safety Dispatcher[~~Telecommunications~~] Career Step, a person shall:

(1) Have active certification as a:

(a) CJIS telecommunicator in accordance with KRS 15.565; or

(b) Non-CJIS telecommunicator in accordance with KRS 15.560;

(2) Complete fifty-six (56) hours of KLEC-approved public safety dispatch courses[~~the Basic Telecommunications Career Step;~~

~~(3) Complete the following courses:~~

~~(a) Eight (8) hours of customer service;~~

~~(b) Eight (8) hours of teambuilding;~~

~~(c) An eight (8) hour KLEC-approved telecommunications ethics course;~~

~~(d) Sixteen (16) hours of cultural awareness;~~

~~(e) Sixteen (16) hours of elective courses from any telecommunications course approved by the KLEC~~]; and

(3)[~~(4)~~] Have one (1) of the following combinations of full-time telecommunications experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Three (3) years of experience and thirty (30) hours of college credit;

(b) Four (4) years of experience and twenty-five (25) hours of college credit;

(c) Five (5) years of experience and twenty (20) hours of college credit;

(d) Six (6) years of experience and fifteen (15) hours of college credit;

(e) Seven (7) years of experience and ten (10) hours of college credit; or

(f) Eight (8) hours of experience and five (5) hours of college credit.

Section 16[~~17~~]. Advanced Public Safety Dispatcher[~~Telecommunicator~~] Certificate. To demonstrate proficiency in the Advanced Public Safety Dispatcher[~~Telecommunications~~] Career Step, a person shall:

(1) Have active certification as a:

(a) CJIS telecommunicator in accordance with KRS 15.565; or

(b) Non-CJIS telecommunicator in accordance with KRS 15.560;

(2) Complete the Intermediate Public Safety Dispatcher[~~Telecommunications~~] Career Step;

(3) Complete fifty-six (56) hours of KLEC-approved public safety dispatch courses[~~the following courses:~~

~~(a) Sixteen (16) hour Emergency Medical Dispatch (EMD) Advanced course;~~

~~(b) Twenty-four (24) hour Fire/HAZMAT Incident course; and~~

~~(c) Sixteen (16) hour tactical dispatch course;~~

~~(4) Complete twenty-four (24) hours of elective courses from any telecommunications course approved by the KLEC~~]; and

(4)[~~(5)~~] Have one (1) of the following combinations of full-time telecommunications experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4) years of experience and forty-five (45) hours of college credit;

(b)[~~(c)~~] Five (5) years of experience and forty (40) hours of college credit;

(c)[~~(d)~~] Six (6) years of experience and thirty-five (35) hours of college credit;

(d)[~~(e)~~] Seven (7) years of experience and thirty (30) hours of college credit;

(e)[~~(f)~~] Eight (8) years of experience and twenty-five (25) hours of college credit; or

(f)[~~(g)~~] Nine (9) years of experience and twenty (20) hours of college credit.

Section 17[~~18~~]. Public Safety Dispatcher[~~Telecommunications~~] Supervisor Certificate. To demonstrate proficiency in the Public Safety Dispatcher[~~Telecommunications~~] Supervisor Career Step, a person shall:

(1) Have active certification as a:

(a) CJIS telecommunicator in accordance with KRS 15.565; or

(b) Non-CJIS telecommunicator in accordance with KRS 15.560;

(2) Complete the Advanced Public Safety Dispatcher[~~Basic Telecommunications~~] Career Step;

(3) Successfully complete Leadership 911 or eighty (80) hours of KLEC-approved public ***safety*** dispatch leadership courses[~~: (a) The forty (40) hour Telecommunications Executive Development course;~~

~~(b) Sixteen (16) hours of supervision training approved by the KLEC;~~

~~(c) An eight (8) hour KLEC-approved telecommunications ethics course, if the telecommunicator has not previously completed the Intermediate telecommunicator certificate; and~~

~~(d) Thirty-two (32) hours of elective course in supervision training approved by the KLEC~~]; and

(4) Have one (1) of the following combinations of full-time public safety dispatch[~~telecommunications~~] experience in a supervisory position and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Two (2) years of experience and an associate's degree;

(b) Three (3) years of experience and fifty-five (55) hours of college credit;

(c) Four (4) years of experience and fifty (50) hours of college credit;

(d) Five (5) years of experience and forty-five (45) hours of college credit;

(e) Six (6) years of experience and forty (40) hours of college credit;

(f) Seven (7) years of experience and thirty-five (35) hours of college credit; or

(g) Eight (8) years of experience and thirty (30) hours of college credit.

Section 18[~~19~~]. Public Safety Dispatcher[~~Telecommunications~~] Manager/Director Certificate. To demonstrate proficiency in the Public Safety Dispatcher[~~Telecommunications~~] Manager/Director Career Step, a person shall:

(1) Have active certification as a:

(a) CJIS telecommunicator in accordance with KRS 15.565; or

(b) Non-CJIS telecommunicator in accordance with KRS 15.560;

(2) Obtain the Public Safety Dispatcher[~~Telecommunications~~] Supervisor Certificate;

(3) Successfully complete Telecommunications Executive Development I, II, and III or 120 hours of KLEC-approved public ***safety*** dispatch leadership courses[~~: (a) The forty (40) hour Telecommunications Executive Development course II;~~

~~(b) The forty (40) hour telecommunications executive development III course; and~~

~~(c) Forty (40) hours of elective supervisory or management courses approved by the KLEC~~]; and

(4) Have one (1) of the following combinations of full-time telecommunications experience in a management position and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Two (2) years of experience and a bachelor's[~~bachelors~~] degree;

(b) Four (4) years of experience and an associate's degree;

(c) Five (5) years of experience and sixty (60) hours of college credit;

(d) Six (6) years of experience and fifty-five (55) hours of college credit;

(e) Seven (7) years of experience and fifty (50) hours of college credit;

(f) Eight (8) years of experience and forty-five (45) hours of college credit;

(g) Nine (9) years of experience and forty (40) hours of college credit; or

(h) Ten (10) years of experience and thirty-five (35) hours of college credit.

Section 19[~~20~~]. Law Enforcement Training Officer. To demonstrate proficiency in the Law Enforcement Training Career Step, a peace officer shall have:

(1) Active peace officer certification in accordance with KRS 15.386(2);

(2) Have successfully completed the following:

(a) Intermediate Law Enforcement Officer Certificate;

(b) Advanced Law Enforcement Officer Certificate; and

(c) 120 hours of in-service training, which shall include:

1. Police Training Officer course;

2. Field Instructor course; and

3. Crisis Intervention Training or Law Enforcement Response to Special Needs Population; and

(3) One (1) of the following combinations of full-time law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4) years of experience and a master's degree;

(b) Six (6) years of experience and a bachelor's degree;

(c) Eight (8)[~~Nine (9)~~] years of experience and an associate's degree;

(d) Eight (8) years of experience and 110 hours of college credit;

(e) Nine (9) years of experience and ninety-five (95) hours of college credit;

(f) Ten (10) years of experience and eighty (80) hours of college credit;

(g) Eleven (11) years of experience and sixty-five (65) hours of college credit; or

(h) Twelve (12) years of experience and fifty (50) hours of college credit.

Section 20[~~21~~]. Law Enforcement Officer Advanced Investigator. To demonstrate proficiency in the Law Enforcement Officer Advanced Investigator Career Step, a peace officer shall have:

(1) Active peace officer certification in accordance with KRS 15.386(2);

(2) Successfully completed the following:

(a) Law Enforcement Officer Investigator Certificate; and

(b) 160 hours of electives in investigations courses approved or recognized by the Kentucky Law Enforcement Council; and

(3) One (1) of the following combinations of full-time law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4) years of experience and a master's degree;

(b) Six (6) years of experience and a bachelor's degree;

(c) Eight (8)[~~Nine (9)~~] years of experience and an associate's degree;

(d) Eight (8) years of experience and 110 hours of college credit;

(e) Nine (9) years of experience and ninety-five (95) hours of college credit;

(f) Ten (10) years of experience and eighty (80) hours of college credit;

(g) Eleven (11) years of experience and sixty-five (65) hours of college credit; or

(h) Twelve (12) years of experience and fifty (50) hours of college credit.

Section 21[~~22~~]. Crime Scene Processing Officer. To demonstrate proficiency in the Crime Scene Processing Officer career

step, a peace officer shall have:

(1) Active peace officer certification in accordance with KRS 15.386(2);

(2) Successfully completed the Kentucky Criminalistics Academy or the National Forensic Academy[: ~~(a) 200 hours of in-service training, which shall include:~~

~~1. Crime Scene Investigations;~~

~~2. Digital Photography; and~~

~~3. Advanced Latent Fingerprints; and~~

~~(b) One (1) of the following:~~

~~1. Eighty (80) hours of electives in Investigations courses offered by the Department of Criminal Justice Training; or~~

~~2. The Kentucky Criminalistics Academy or the National Forensic Academy~~]; and

(3) One (1) of the following combinations of full-time law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4) years of experience and a master's degree;

(b) Six (6) years of experience and a bachelor's degree;

(c) Eight (8)[~~Nine (9)~~] years of experience and an associate's degree;

(d) Eight (8) years of experience and 110 hours of college credit;

(e) Nine (9) years of experience and ninety-five (95) hours of college credit;

(f) Ten (10) years of experience and eighty (80) hours of college credit;

(g) Eleven (11) years of experience and sixty-five (65) hours of college credit; or

(h) Twelve (12) years of experience and fifty (50) hours of college credit.

Section 22. Crime Scene Technician. To demonstrate proficiency in the Crime Scene Technician career step, a peace officer shall have:

(1) Active peace officer certification in accordance with KRS 15.386(2);

(2) Successfully completed the Crime Scene Technician portion of the Kentucky Criminalistics Academy or have completed any of the following courses to equal not less than 200 hours:

(a) Bloodstain Pattern Recognition;

(b) Forensic Mapping;

(c) CAD Zone;

(d) Fingerprint Pattern Recognition and Comparison Techniques;

(e) Digital Photography;

(f) Advanced Latent Fingerprints;

(g) Crime Scene Investigation; or

(h) Any KLEC-approved course equivalents; and

(3) Have one (1) of the following combinations of full-time law enforcement experience and credits from an accredited college or university, recognized by the Kentucky Council on Postsecondary Education:

(a) Four (4) years of experience and a master's degree;

(b) Six (6) years of experience and a bachelor's degree;

(c) Eight (8) years of experience and an associate's degree;

(d) Eight (8) years of experience and 110 hours of college credit;

(e) Nine (9) years of experience and ninety-five (95) hours of college credit;

(f) Ten (10) years of experience and eighty (80) hours of college credit;

(g) Eleven (11) years of experience and sixty-five (65) hours of college credit; or

(h) Twelve (12) years of experience and fifty (50) hours of college credit.

Section 23. Certificate of Completion. The KLEC shall issue a certificate and uniform lapel pin to a peace officer or telecommunicator upon completion of a career development step.

Section 24. Maintenance of Records. All training records shall be maintained in accordance with applicable provisions of KRS Chapter 171.

Section 25. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Career Development Program Participant Commitment Form," Form 1, February 2013[~~KLEC Form CDP-1, June 2010~~];

(b) "Intermediate Law Enforcement Officer", Form 2, February 2013[~~KLEC Form CDP-2, November 2008~~];

(c) "Advanced Law Enforcement Officer", Form 3, February 2013[~~KLEC Form CDP-3, November 2008~~];

(d) "Law Enforcement Officer Investigator", Form 4, February 2013[~~KLEC Form CDP-4, November 2008~~];

(e) "Law Enforcement Traffic Officer", Form 5, February 2013[~~KLEC Form CDP-5, November 2008~~];

(f) "Advanced Deputy Sheriff", Form 6, February 2013[~~KLEC Form CDP-6, November 2008~~];

(g) "Law Enforcement Supervisor", Form 7, February 2013[~~KLEC Form CDP-7, November 2008~~];

(h) "Law Enforcement Manager ", Form 8, February 2013[~~KLEC Form CDP-8, November 2008~~];

(i) "Law Enforcement Executive", Form 9, February 2013[~~KLEC Form CDP-9, November 2008~~

~~(j) "Basic Telecommunicator", KLEC Form CDP-10, November 2008~~];

(j)[~~(k)~~] "Intermediate Public Safety Dispatcher", Form 11, February 2013[~~Telecommunicator", KLEC Form CDP-11, July 2010~~];

(k)[~~(l)~~] "Advanced Public Safety Dispatcher," Form 12, February 2013[~~Telecommunicator", KLEC Form CDP-12, June 2010~~];

(l) "Public Safety Dispatcher[~~(m) "Telecommunications~~] Supervisor", Form 13, February 2013[~~KLEC Form CDP-13, June 2010~~];

(m) "Public Safety Dispatcher[~~(n) "Telecommunications~~] Manager/Director", Form 14, February 2013[~~KLEC Form CDP-14, June 2010~~];

(n)[~~(o)~~] "Law Enforcement Chief Executive", Form 15, February 2013[~~KLEC Form CDP-15, November 2008~~];

(o)[~~(p)~~] "Law Enforcement Training Officer", Form 16, February 2013[~~KLEC Form CDP-16, November 2008~~];

(p)[~~(q)~~] "Law Enforcement Officer Advanced Investigator", Form 17, February 2013[~~KLEC Form CDP-17, November 2008~~];

(q)[~~(r)~~] "Crime Scene Processing Officer", Form 18, February 2013;[~~KLEC Form CDP-18, November 2008; and~~]

(r)[~~(s)~~] "Communications Training Officer", Form 19, February 2013; and

(s) "Crime Scene Technician," Form 20, February 2013[~~KLEC Form CDP-19, June 2010~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Criminal Justice Training, Funderburk Building, Eastern Kentucky University, 521 Lancaster Road, Richmond, Kentucky 40475-3102, Monday through Friday, 8 a.m. to 4:30 p.m.

KEITH R. CAIN, Chair

APPROVED BY AGENCY: March 14, 2013

FILED WITH LRC: March 14, 2013 at 1 p.m.

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CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner's Office
(As Amended at ARRS, May 14, 2013)

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

STATUTORY AUTHORITY: KRS 194A.010(1), 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

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 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; or

(e) The failure of a managed care organization to act within the timeframes provided in 42 C.F.R. 438.408(b).

(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***:***

(a) For an enrollee who is authorized by Kentucky law to provide written consent, an individual or entity acting on behalf of, and with written consent from, ***the[~~an~~]*** enrollee***; or***

(b) A legal guardian.

(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)[~~(7)~~] "Blind" is defined by 42 U.S.C. 1382c(a)(2).

(9)[~~(8)~~] "Capitation payment" means the total per enrollee, per month payment amount the department pays an MCO.

(10)[~~(9)~~] "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)[~~(10)~~] "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)[~~(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;

(b) Is characterized by advocacy, communication, and resource management;

(c) Promotes quality and cost-effective interventions and outcomes; and

(d) Is in addition to and not in lieu of targeted case management for:

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.

(13)[~~(12)~~] "CHFS OIG" means the Cabinet for Health and Family Services, Office of Inspector General.

(14)[~~(13)~~] "Child" means a person who:

(a)1. Is under the age of eighteen (18) years;

2.a. Is a full-time student in a secondary school or the equivalent level of vocational or technical training; and

b. 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(l)(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)[~~(15)~~] "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)[~~(18)~~] "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)[~~(19)~~] "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)[~~(20)~~] "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.

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

(25)[~~(24)~~] "DSM-IV" means a manual published by the American Psychiatric Association that covers all mental health disorders for both children and adults.

(26)[~~(25)~~] "Dual eligible" means an individual eligible for Medicare and Medicaid benefits.

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

(28)[~~(27)~~] "Emergency service" means "emergency services" as defined by 42 U.S.C. 1396u-2(b)(2)(B).

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

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

(31)[~~(30)~~] "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)[~~(31)~~] "Family planning service" means a counseling service, medical service, or
a pharmaceutical supply or device to prevent or delay pregnancy.

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

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

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

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

(37)[~~(36)~~] "Grievance" is defined by 42 C.F.R. 438.400.

(38)[~~(37)~~] "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)[~~(38)~~] "Health maintenance organization" is defined by KRS 304.38-030(5).

(40)[~~(39)~~] "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)[~~(40)~~] "Healthcare Effectiveness Data and Information Set" or "HEDIS" means a tool used to measure performance regarding important dimensions of health care or services.

(42)[~~(41)~~] "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)[~~(42)~~] "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.

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

(45)[~~(44)~~] "KCHIP" means the Kentucky Children's Health Insurance Program administered in accordance with 42 U.S.C. 1397aa to jj.

(46)[~~(45)~~] "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)[~~(46)~~] "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)[~~(47)~~] "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)[~~(48)~~] "Maternity care" means prenatal, delivery, and postpartum care and includes care related to complications from delivery.

(50)[~~(49)~~] "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)[~~(50)~~] "Medical record" means a single, complete record that documents all of the treatment plans developed for, and medical services received by, an individual.

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

(53)[~~(52)~~] "Medicare qualified individual group 1 (QI-1)" means an eligibility category ***that includes***,~~***[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 ***is***~~***[are]***~~ not otherwise eligible for Medicaid under the state plan.

(54)[~~(53)~~] "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.

(55)[~~(54)~~] "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).

(56)[~~(55)~~] "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. 1395tt and 1396l, 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.

(57)[~~(56)~~] "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."

(58)[~~(57)~~] "Open enrollment" means an annual period during which an enrollee can choose a different MCO.

(59)[~~(58)~~] "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.

(60)[~~(59)~~] "Physician" is defined by KRS 311.550(12).

(61)[~~(60)~~] "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.

(62)[~~(61)~~] "Primary care center" means an entity that meets the primary care center requirements established in 902 KAR 20:058.

(63)[~~(62)~~] "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~~].

(64)[~~(63)~~] "Prior authorization" means the advance approval by an MCO of a service or item provided to an enrollee.

(65)[~~(64)~~] "Provider" means any person or entity under contract with an MCO or its contractual agent that provides covered services 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)~~] "QAPI" 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. 1396d(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) "Region eight (8)" means the region containing Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe Counties.

(74) "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) "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.

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

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

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

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

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

(81)[~~(72)~~] "Risk adjustment" means a corrective tool to reduce both 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.

(82)[~~(73)~~] "Rural area" means an area not in an urban area.

(83)[~~(74)~~] "Rural health clinic" is defined by 42 C.F.R. 405.2401(b).

(84)[~~(75)~~] "Specialist" means a provider who provides specialty care.

(85)[~~(76)~~] "Specialty care" 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.

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

(87)[~~(78)~~] "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.

(88)[~~(79)~~] "State plan" is defined by 42 C.F.R. 400.203.

(89)[~~(80)~~] "State survey agency" means the Cabinet for Health and Family Services, Office of Inspector General, Division of Health Care Facilities and Services.

(90)[~~(81)~~] "State-funded adoption assistance" is defined by KRS 199.555(2).

(91)[~~(82)~~] "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.

(92)[~~(83)~~] "Supplemental security income benefits" or "SSI benefits" is defined by 20 C.F.R. 416.2101.

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

(94)[~~(85)~~] "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.

(95)[~~(86)~~] "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.

(96)[~~(87)~~] "Transport time" means travel time:

(a) Under normal driving conditions; and

(b) With no extenuating circumstances.

(97)[~~(88)~~] "Urban area" is defined by 42 C.F.R. 412.62(f)(1)(ii).

(98)[~~(89)~~] "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.

(99)[~~(90)~~] "Ward" is defined in KRS 387.510(15).

(100)[~~(91)~~] "Women, Infants and Children program" means a federally-funded health and nutrition program for women, infants, and children.[~~Section 2. 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:~~

~~(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 1:805;~~

~~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;~~

~~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)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.a. Annually during an open enrollment period that shall be at the time of an enrollee's recertification for Medicaid eligibility; or~~

~~b. Annually during the month of birth for an enrollee who receives SSI benefits;~~

~~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~~

~~4. When the Commonwealth of Kentucky imposes an intermediate sanction specified in 42 C.F.R. 438.702(a)(3).~~

~~(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) 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. 233.100.~~

~~3. If an enrollee is retro-actively determined eligible for Medicaid, the retro-active eligibility shall be 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, 2011.~~

~~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 beginning on or after November 1, 2011.~~

~~(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 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 2(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.~~

~~(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.~~

~~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 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).~~

~~(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 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 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)1. 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 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:~~

~~(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 (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.~~

~~(18) For an extension 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 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;~~

~~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.~~

~~(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 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; 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 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)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 or place of employment if the enrollee is in an urban area; or~~

~~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.~~

~~(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 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 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; 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 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 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).~~

~~(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 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. 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.(i) Selecting or requesting to change a PCP;~~

~~(ii) A reason 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~~

~~e. 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-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. 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 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;~~

~~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 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)(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 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)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:~~

~~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;~~

~~2. Authorized after being provided if the service was not prior authorized; and~~

~~3. Covered in accordance with Section 29(1) of this administrative regulation.~~

~~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, 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. 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~~

~~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 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;~~

~~(b) Have and maintain documentation regarding a provider's qualifications; and~~

~~(c) Make 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 request from the MCO.~~

~~(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.~~

~~(2) An enrollee medical record shall:~~

~~(a) Be legible, current, detailed, organized, and signed by the service provider;~~

~~(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~~

~~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 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 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 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 26. 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 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;~~

~~(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 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) Breckenridge;~~
~~(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) McCreary;~~
~~(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) Franklin;~~
~~(h) Garrard;~~
~~(i) Harrison;~~
~~(j) Jackson;~~
~~(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;~~
~~(b) Boyd;~~
~~(c) Bracken;~~
~~(d) Carter;~~
~~(e) Elliott;~~
~~(f) Fleming;~~
~~(g) Greenup;~~
~~(h) Lawrence;~~
~~(i) Lewis;~~
~~(j) Mason;~~
~~(k) Menifee;~~
~~(l) Morgan;~~
~~(m) Rowan; and~~
~~(n) Robertson.~~
~~(10) Region eight (8) shall include the following counties:~~
~~(a) Bell;~~
~~(b) Breathitt;~~
~~(c) Clay;~~
~~(d) Floyd;~~
~~(e) Harlan;~~
~~(f) Johnson;~~
~~(g) Knott;~~
~~(h) Knox;~~
~~(i) Laurel;~~
~~(j) Lee;~~
~~(k) Leslie;~~
~~(l) Letcher;~~
~~(m) Magoffin;~~
~~(n) Martin;~~
~~(o) Owsley;~~
~~(p) Perry;~~
~~(q) Pike;~~
~~(r) Wolfe; and~~
~~(s) Whitley.~~

~~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) Except as established in Section 35 of this administration regulation, a school-based health service;~~

~~(f) A service not covered by the Kentucky Medicaid program;~~

~~(g) A health access nurturing developing service pursuant to 907 KAR 3:140;~~

~~(h) 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) 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 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)(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 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;~~

~~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 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, 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 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(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;~~

~~(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) 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)(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 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 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 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 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 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;~~

~~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 guar-~~

~~dian, 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 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 a:~~

~~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 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 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 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~~

~~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. 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 45 of this administrative regulation.~~

~~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 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 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 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;~~

~~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 preadmission 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;~~

~~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 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 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;~~

~~(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 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) 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 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 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 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.~~

~~(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. 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 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 healthcare 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 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 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 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. 1396a(a)(37), an MCO shall have prepayment and postpayment 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)(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 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 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;~~

~~(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 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 for one (1) calendar month, 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;~~

~~(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:~~

~~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. 438.242and 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 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; 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 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 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 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 Periodicity Schedule", July 2011 edition;~~

~~(d) "Third Party Liability and Coordination of Benefits", July 2011 edition; and~~

~~(e) "Management Information Systems Requirements", 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.

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CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner's Office
(As Amended at ARRS, May 14, 2013)

907 KAR 17:010. 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.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 1.G.3.b.(17)

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:

(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 ***an intellectual[~~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 1:805;

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 ***an intellectual[~~mental retardation or a developmental~~]*** disability; or

e. Medicaid benefits as a Medicaid Works individual;

3. A Qualified Medicare beneficiary who is not otherwise eligible for Medicaid benefits;

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 qualified alien eligible for Medicaid benefits for a limited period of time; or

8. 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 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) 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 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

4. When the Commonwealth of Kentucky imposes an intermediate sanction specified in 42 C.F.R. 438.702(a)(3).

(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. ***Except as provided in paragraph (e) of this subsection,*** 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 ***established[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)***, or[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 ***requirements established[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:

(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)(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), ***or[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.

(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 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)***1. For authorized representative purposes, written consent unique to an appeal or state fair hearing shall be required for the appeal or state fair hearing.***

2. A single written consent shall not qualify as written consent for more than one (1):

a. Hospital admission;

b. Physician or other provider visit; or

c. Treatment plan.[~~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 ***or an individual listed in subsection (5) of this section*** 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. ***A copy of this information shall also be sent to an individual listed in subsection (5) of this section, if applicable.***

(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 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)(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 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)(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 ***the MCO receives*** 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; ***or[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;

(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 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)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 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 health care need, a disability, or chronic illness, be a specialist who agrees to provide or arrange for primary and preventive care.

(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; 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 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) 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.***[~~(i)~~]*** Selecting or requesting to change a PCP***, which shall include:***

(i)[~~; (ii)~~] A reason a request for a change may be denied by the MCO; ***and***

(ii)[~~(iii)~~] A reason a provider may request to transfer an enrollee to a different PCP; and

e. 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 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;

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 **and Liability** for Payment. (1)**(a)** 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.

(b) An enrollee may be liable for the costs of services received during an appeal process in accordance with:

1. 907 KAR 17:025, Section 2(4)(b)2g;

2. 42 C.F.R. 431.230; or

3. 42 C.F.R. 438.404.

(2)**(a)** An MCO shall not impose cost sharing on an enrollee greater than the limits established by the department in 907 KAR 1:604.

(b) An MCO operating in Region 3 shall not impose cost sharing on an enrollee enrolled with the MCO in Region 3 prior to January 1, 2014.

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)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 ***shall[~~may~~]*** be demonstrated by evidence of***:***

a. A return receipt if sent via U.S. Mail***;***

b.[,] A read receipt if sent via e-mail***;[,]*** or

c. 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 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 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 ***survey[~~surveys~~]*** referenced in paragraph (a) of this subsection;

2. A description of a methodology to be used to conduct ***each survey[~~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)**(a)** In accordance with 42 C.F.R. 438.208***.[~~:~~***

***1.[~~a.~~]*[~~(a)~~]** the following shall be considered an individual with a special health care need:

***1.[~~a.~~]*[~~1.~~]** A child in or receiving foster care or adoption assistance;

***2.[~~b.~~]*[~~2.~~]** A homeless individual;

***3.[~~c.~~]*[~~3.~~]** An individual with a chronic physical or behavioral illness;

***4.[~~d.~~]*[~~4.~~]** A blind or disabled child;

***5.[~~e.~~]*[~~5.~~]** An individual who is eligible for SSI benefits; or

6.[~~f.~~]*[~~6.~~]** An adult who is a ward of the Commonwealth in accordance with 910 KAR Chapter 2.[~~; and~~]***

(b) **In accordance with 42 C.F.R. 438.208,** 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.

(c)1. 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.

2.a. The service plan referenced in *subparagraph 1.[~~paragraph (a)~~]* of this *paragraph[~~subsection~~]* shall be used by DCBS and the MCO to determine the enrollee's medical needs and to identify if there is a need for case management.

b. 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. *The child's caretaker may attend each meeting held to discuss the health care needs of that child.*

c. 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.

d. The MCO shall consult with DCBS prior to developing or modifying a case management plan of care.

e. If the service plan accomplishes a requirement stated in paragraph (b) of this subsection, the requirement stated in subsection (b) shall be considered to have been met.

(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: April 5, 2013

FILED WITH LRC: April 5, 2013 at 11 a.m.

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CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner's Office
(As Amended at ARRS, May 14, 2013)

907 KAR 17:015. 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

STATUTORY AUTHORITY: KRS 194A.010(1), 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

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***, Section 5***;

(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) Exclude, terminate, or suspend from its network a provider or subcontractor who engages in an activity that results in suspension, termination, or exclusion from ***a[~~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 ***a[~~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 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 ***17[~~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)*** A hospital ***located in Region 1, Region 2, Region 4, Region 5, Region 6, Region 7, or Region 8*** shall be within:

1. Thirty (30) miles or thirty (30) minutes from an enrollee's residence in an urban area; or

2. Sixty (60) minutes of an enrollee's residence in a non-urban area.

(b) A hospital located in Region 3 shall be within:

1.[(a)] Thirty (30) miles or thirty (30) minutes of an enrollee's residence in an urban area; or

2.[(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 ***in:***

(a) Region 1, Region 2, Region 4, Region 5, Region 6, Region 7, or Region 8 shall be within sixty (60) minutes of an enrollee's residence; or

(b) Region 3 shall be within sixty (60) miles or sixty (60) minutes of an enrollee's residence.

(9)(a) A dental service ***in:***

1. Region 1, Region 2, Region 4, Region 5, Region 6, Region 7, or Region 8 shall be within sixty (60) minutes of an enrollee's residence; or

2. Region 3 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 ***in:***

1. Region 1, Region 2, Region 4, Region 5, Region 6, Region 7, or Region 8 shall be within sixty (60) minutes of an enrollee's residence; or

2. Region 3 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.

(11)(a) A pharmacy service ***in:***

1. Region 1, Region 2, Region 4, Region 5, Region 6, Region 7, or Region 8 shall be within sixty (60) minutes of an enrollee's residence; or

2. Region 3 shall be within sixty (60) miles or sixty (60) minutes of 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.

(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 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;

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;

(b) Have and maintain documentation regarding a provider's qualifications; and

(c) Make 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 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. 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

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***:***

1. By November 1, 2015, for an MCO that began participating November 1, 2011;

2. By January 1, 2017, for an MCO that began participating January 1, 2013; or

3. Within four (4) years of the date an MCO begins participation, for an MCO that did not begin participating by the effective date[~~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***, Section 5***;
(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 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 12 of this administrative regulation[~~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***:***
1. Within the MCO's network; or
2. If the services are not available within the MCO's network, outside the MCO's network[~~, 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)1. 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;

(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

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 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 ***survey[~~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 TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 18, 2012

FILED WITH LRC: December 21, 2012 at 4 p.m.

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CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner's Office
(As Amended at ARRS, May 14, 2013)

907 KAR 17:020. Managed care organization service and service coverage requirements and policies.

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.030(2), 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 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 205.520(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 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 1:720; 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) 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 Post-stabilization 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) Post-stabilization 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.

(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.

(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)(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***, Section 2***;

(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) ***or[~~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 ***or[~~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 a:

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.

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@ky.gov.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Commissioner's Office
(As Amended at ARRS, May 14, 2013)

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

STATUTORY AUTHORITY: KRS 194A.010(1), 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

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 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 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. 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. 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 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 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;

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 preadmission 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. 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 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; 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 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 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 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. 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 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 healthcare needs of enrollees including:

(a) The enrollee population;

(b) A subpopulation of the enrollee population; and

(c) ***A*** 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.

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@ky.gov.

ADMINISTRATIVE REGULATIONS AMENDED AFTER PUBLIC HEARING OR RECEIPT OF WRITTEN COMMENTS

NONE

PROPOSED AMENDMENTS

PERSONNEL CABINET
Office of the Secretary
(Amendment)

101 KAR 2:076. Vacancies, detail to special duty and temporary overlap.

RELATES TO: KRS 18A.005, 18A.110(1)(g), (7), 18A.115, 18A.120

STATUTORY AUTHORITY: KRS 18A.030(2), 18A.110(1)(g), (7)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 18A.110(1)(g) and (7) requires the Secretary of Personnel to promulgate administrative regulations which govern the types of appointments and are necessary to implement KRS Chapter 18A. This administrative regulation establishes the requirements for filling a vacancy, for detail to special duty, and for temporary overlap.

Section 1. Filling of Vacancies. A vacancy in the classified service, which is not filled by promotion, transfer, or demotion, shall be filled by probationary appointment, reemployment of a career or laid-off employee, reversion, or reinstatement.

Section 2. Detail to Special Duty. (1) If the services of an employee with status are needed in a position within an agency other than the position to which the employee is regularly assigned, the employee may be detailed to that position for a period not to exceed one (1) year with prior approval of the secretary.

(2) For detail to special duty, the secretary may waive the minimum requirements if requested and justified by the appointing authority in writing.

(3) Upon approval by the secretary, the appointing authority shall notify the employee, in writing, of:

(a) The detail to special duty;

(b) The reasons for the action; and

(c) The employee's retention of status in the position from which he was detailed to special duty.

Section 3. Temporary Overlap. With the approval of the secretary, an agency may place an employee in a position currently occupied by another employee for a period not to exceed ninety (90)[~~sixty (60)~~] calendar days, for training purposes or if it is in the best interests of the service.

TIM LONGMEYER, Cabinet Secretary

APPROVED BY AGENCY: May 14, 2013

FILED WITH LRC: May 15, 2013 at 11a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Monday, June 24, 2013 at 9:30 a.m. at 501 High Street, 3rd Floor, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing within 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. 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 July 1, 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: Dinah T. Bevington, Office of Legal Services, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601, phone (502) 564-7430, fax (502) 564-0224.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Dinah T. Bevington

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation addresses vacancies, detail to special duty and temporary overlap in the classified service.

(b) The necessity of this administrative regulation: This regulation is necessary for the effective and proper application of requirements for employees in the classified service.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 18A.030 and 18A.110 (1)(c), (d), (g) and (7) require the Secretary of Personnel to promulgate comprehensive administrative regulations for the classified service governing the classification and compensation plan. This regulation addresses the handling of positions within the classified service.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation currently specifies requirements for vacancies, detail to special duty and temporary overlap for employees in the classified service.

(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 regulation, as amended, changes the period of temporary overlap from sixty (60) days to ninety (90) days.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to promote efficiency in the classified service. The change from sixty (60) days to ninety (90) days is necessary because this is the mechanism to allow an employee to perform the duties of another employee who may be off on extended medical or military leave. This will assist in cross-training efforts as well, such as when an employee is separating from state service and another employee has been selected for the position. Additionally, the life of a register certificate during which an appointment or promotion action must be taken is ninety (90) days (101 KAR 2:066). This amendment will make these time frames consistent.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment complies with KRS 18A.030(2), 18A110(1)(c)(d)(g) and (7).

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide relief to state agencies by ensuring work is performed in the absence of key personnel.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All KRS Chapter 18A classified employees are subject to the provisions of 101 KAR 2:076.

(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 actions are required to comply with the amendment.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3)? Since there are no actions required to comply with the amendment, there are no additional costs anticipated to each of the entities identified.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3)? This change will provide flexibility to agencies to ensure the continued operation of services. A temporary overlap can be used for training purposes such as when an employee is separating from state service and another employee has been selected for the position. A temporary overlap can also be used to place an employee in a position that is currently occupied but the incumbent employee is excused from work by medical or military leave. A temporary overlap has to be approved by the Secretary of the Personnel Cabinet and consecutive overlaps are

discouraged. The extra time will assist agencies and eliminate administrative paperwork. Executive Branch agencies will not have to use the 90 days, but this provides relief for long term situations.

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

(a) Initially: This regulation, as amended, is not anticipated to create additional costs. This amendment does not result in the hiring of additional personnel, but instead assists in the coverage of current work demands by current employees.

(b) On a continuing basis: This regulation, as amended, is not anticipated to create additional costs.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation? If any, the funding for any additional cost will be at the agency level. This is a discretionary personnel action that can be utilized by an agency and is not 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: This regulation, as amended, is not anticipated to require additional funding.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This regulation, as amended, is not anticipated to generate any new or additional fees.

(9) TIERING: Is tiering applied? No. All merit, classified employees are treated the same.

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? All state agencies with employees covered under KRS Chapter 18A.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 18A.030 (2), 18A.110 (1)(c), (d), (g) and (7).

(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.

(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.

(c) How much will it cost to administer this program for the first year? There are no estimated additional costs within this regulation as amended.

(d) How much will it cost to administer this program for subsequent years? There are no estimated additional costs within this regulation as amended.

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:

PERSONNEL CABINET
Office of the Secretary
(Amendment)

101 KAR 2:095. Classified service administrative regulations.

RELATES TO: KRS 18A.030(2), 18A.110

STATUTORY AUTHORITY: KRS 18A.030, 18A.110

NECESSITY, FUNCTION, AND CONFORMITY: KRS 18A.110 requires the Secretary of Personnel to promulgate comprehensive administrative regulations for the classified service. This administrative regulation establishes requirements for the classified service which govern the maintenance of employee and other records and reports in the cabinet and other conditions of employment.

Section 1. Definitions. (1) "Approved charitable federation" means a charitable organization which:

(a) Qualifies as a charitable federation with a substantial Kentucky presence; and

(b) Has been approved by the Secretary of Personnel for participation in the campaign pursuant to Section 8(3) of this administrative regulation.

(2) "Charitable federation" means a legally constituted grouping, made up of or supporting at least ten (10) health and human welfare organizations, all of which:

(a) Qualify as exempt voluntary charitable organizations under 26 U.S.C. 501(c)(3); and

(b) Have a substantial Kentucky presence.

(3) "Designated nonprofit agency" means an organization with proof of tax-exempt status under 26 U.S.C. 501(c)(3) which is written in on a pledge card by a state employee as a choice to receive contributions.

(4) "State employee" means a person, including an elected public official, who is employed by a department, board, agency or branch of state government, except one (1) relating to a state college or university.

(5) "Substantial Kentucky presence" means a facility, staffed by professionals or volunteers, available to provide its services and open at least fifteen (15) hours a week and with a regional or statewide presence that meets the requirements of Section 8(2) of this administrative regulation.

Section 2. Attendance; Hours of Work. (1) The number of hours a full-time employee shall be required to work shall be thirty-seven and one-half (37 1/2) hours per week or forty (40) hours per week, unless specified otherwise by the appointing authority or the statutes.

(2) The normal work day shall be from:

(a) 8 a.m. to 4:30 p.m., local time, Monday through Friday, for a thirty-seven and one-half (37 1/2) hour work schedule; or

(b) 8 a.m. to 5 p.m., local time, Monday through Friday, for a forty (40) hour work schedule.

(3) An appointing authority may require an employee to work hours and days other than regular days and hours, including an overtime or inclement weather schedule if it is in the best interest of the agency.

(4) An employee who works for an agency which requires more than one (1) shift or seven (7) days a week operation may be reassigned from one shift to another or from one post to another or alternate days off by the agency to meet staffing requirements or to maintain security or provide essential services of the agency.

(5) An employee shall give reasonable notice in advance of absence from a work station.

Section 3. Work Station and Temporary Assignment. (1) Each employee shall be assigned a work station by the appointing authority.

(2) A work station may be changed to better meet the needs of the agency.

(3) An employee may be temporarily assigned to a different work station in a different county for a period of up to sixty (60) calendar days. Temporary assignment may be renewed with the approval of the Secretary of Personnel. A temporarily reassigned employee shall be reimbursed for travel expenses in accordance with regulatory provisions and the appointing authority shall notify the employee in writing prior to the effective date of the action.

(4) An appointing authority may assign an employee to work in a different site within the county of employment.

Section 4. Dual Employment. (1) An employee holding a full-time position with the Commonwealth shall not hold another state position except upon recommendation of the appointing authority and the written approval of the secretary.

(2) A complete list of all employees holding more than one (1)

state position shall be furnished to the Legislative Research Commission quarterly by the secretary.

Section 5. Notice of Resignation and Retirement. (1) An employee who desires to terminate his service with the state shall submit a written resignation or notice of retirement to the appointing authority.

(2) A resignation or notice of retirement shall be submitted at least fourteen (14) calendar days before the final working day. A copy of an employee's resignation shall be attached to the personnel action effecting the separation and be filed in the employee's service record in the agency and the Personnel Cabinet.

(3) Failure of an employee to give fourteen (14) calendar days notice with his resignation or notice of retirement may result in forfeiture of accrued annual leave.

(4) The effective date of a separation shall be the last work day unless the employee has been approved for the use of annual, compensatory, or sick leave prior to termination.

Section 6. Records and Reports. (1) An appointing authority shall provide a request to the Personnel Cabinet for a personnel action or status change.

(a) The Secretary of the Personnel Cabinet shall determine which personnel actions warrant a Personnel Action Notification to the employee, in accordance with KRS 18A.020 and 18A.095.

(b) The secretary shall provide a Personnel Action Notification to the appointing authority.

(c) The appointing authority shall provide a copy of a Personnel Action Notification to the employee affected by the action.

(2) The secretary shall maintain a leave record showing for each employee:

(a) Annual leave earned, used and unused;

(b) Sick leave earned, used and unused;

(c) Compensatory leave earned, used and unused; and

(d) Special leave or other leave with or without pay.

Section 7. Telecommuting. (1) Telecommuting shall be a work arrangement where a selected state employee is allowed to perform the normal duties and responsibilities of his position through the use of computer or telecommunications at home or another place apart from the employee's usual work station.

(2) An appointing authority may establish a telecommuting program for all or any part of the agency.

(3) Eligibility and selection for participation in a telecommuting program shall be the decision of the agency, with no implied or specific right to participation being granted to an employee.

(4) The telecommuter's conditions of employment shall remain the same as for a nontelecommuting employee.

(a) Employee salary, benefits and employer-sponsored insurance coverage shall not change as a result of telecommuting.

(b) The telecommuter shall be responsible for the security and confidentiality of data, as well as the protection of state-provided equipment, used and accessed during telecommuting.

(c) The telecommuter shall agree to maintain a clean, safe workplace.

(d) An on-site visit by the employer for monitoring of safety issues shall be arranged in advance.

Section 8. Requirements for the Kentucky Employees Charitable Campaign. (1) General Purpose. The purpose of the Kentucky Employees Charitable Campaign shall be to:

(a) Provide an opportunity for employees to contribute to eligible Kentucky organizations through the state's payroll deduction process;

(b) Ensure accountability for participants in regard to the funds raised;

(c) Encourage the involvement of state employees as responsible citizens;

(d) Give recognition to state employee volunteers; and

(e) Minimize workplace disruption and administrative costs to Kentucky taxpayers by allowing only one (1) statewide payroll deduction charitable solicitation per year.

(2) An organization shall be considered to have a substantial Kentucky presence if the requirements established in this subsection are met.

(a) Services shall be available to state employees in the local community.

(b) Services shall directly benefit human beings whether children, youth, adults, the aged, the ill and infirm, or the mentally or physically disabled.

(c) Services shall consist of:

1. Care, research, education or prevention in the fields of human health or social adjustment and rehabilitation;

2. Relief for victims of natural disasters and other emergencies; or

3. Assistance to those who are impoverished and in need of food, shelter, clothing and basic human welfare services.

(3) The secretary shall approve a charitable organization for participation in the campaign if the charitable organization demonstrates:

(a) Proof of tax exempt status under 26 U.S.C. 501(c)(3);

(b) Proof of current registration and compliance with the reporting requirements of the Secretary of State and the Office of the Attorney General;

(c) Proof of financial responsibility, including:

1. Adoption of a detailed annual budget;

2. Use of generally accepted accounting principles and procedures;

3. The board of directors' approval for deviations from the approved budget; and

4. An annual financial audit;

(d) Proof of direction by an active volunteer board of directors which meets regularly and whose members serve without compensation;

(e) A written nondiscrimination policy;

(f) Public disclosure of fundraising administrative costs with a statement demonstrating that, if fund and administrative expenses are in excess of twenty-five (25) percent of total support and revenue, actual expenses for those purposes are reasonable under all the circumstances in its case; and

(g) Publication of an annual report available to the general public, which includes a full description of the organization's Kentucky activities including fundraising activities.

(4) A federation may apply on behalf of all their member organizations if both the federation and all federation members meet the criteria established in subsection (3) of this section.

(5) Authority of the Secretary of Personnel.

(a) The Secretary of Personnel shall have the full authority over the procedures and policies relating to the operation of the Kentucky Employees Charitable Campaign.

(b) The secretary shall designate a group of state employees to compose the Kentucky Employees Charitable Campaign Committee to make recommendations on related matters.

(c) The committee shall be composed of a cross-section of state employees, involving the large cabinets and small agencies.

(d) The chair of the committee shall be appointed by the secretary.

(6) Functions of the committee. The committee shall make recommendations on the following:

(a) Designation of a campaign administrator.

1. The campaign administrator shall serve for a minimum period of two (2) years.

2. The campaign administrator shall be charged to manage and administer the charitable fund campaign for the Commonwealth, subject to the direction and control of the Secretary of Personnel. The campaign administrator shall have statewide workplace campaign experience and have the necessary staff and volunteer support to administer the Kentucky Employee Charitable Campaign;

(b) Establishment of minimum amount, based on cost effectiveness, that an employee may authorize to be deducted for each approved federation;

(c) The format of the brochure, pledge card and other promotional materials for the annual campaign;

(d) The dates and duration of the campaign;

(e) The annual campaign budget submitted by the campaign administrator; and

(f) The costs of the campaign, which shall be detailed in the

budget, and which shall be borne by each recipient organization proportionally.

(7) Charitable federations to apply for statewide campaign.

(a) A federation desiring inclusion shall make application by February 15 of each year.

(b) A federation that has previously participated in the campaign shall update its application with a letter and a copy of the most recent year's audit.

(c) A charitable organization that has previously participated in the campaign shall be eligible if it fulfills all conditions of eligibility.

(8) The campaign administrator. The campaign administrator shall:

(a) Provide staffing to manage and administer the annual campaign. This shall include preparing drafts of campaign materials for consideration by the Secretary of Personnel;

(b) Serve as the central accounting point for both campaign cash and for payroll deductions received from the Personnel Cabinet including:

1. The preparation and submission of an annual campaign budget. Costs of the campaign shall be divided among recipient organizations; and

2. A separate account maintained for managing the income and expenses of the campaign;

(c) Distribute campaign funds received from the Personnel Cabinet to participating organizations in accordance with agreed upon time periods. This shall include distribution of funds to designated nonprofit agencies;

(d) Provide an end-of-campaign report to the Secretary of Personnel and to participating organizations; and

(e) Annually furnish a financial statement prepared by a certified public accountant.

Section 9. Workplace Violence Policy. (1) Workplace violence shall be prohibited and include:

(a) The attempted, threatened, or actual conduct of a person who endangers or is likely to endanger the health and safety of state employees or the general public; or

(b) A threatening statement, harassment or behavior that gives a state employee or member of the general public reasonable cause to believe that his health or safety is at risk.

(2) Examples of prohibited workplace violence shall include:

(a) Threats of harm;

(b) Brandishing or displaying a weapon or an object that looks like a weapon in a manner which would present a safety risk to a state employee or a member of the general public or threatens or intimidates them;

(c) Intimidating, threatening, or directing abusive language toward another person, either verbally, in writing or by gesture;

(d) Stalking;

(e) Striking, slapping or otherwise physically attacking another person; or

(f) Disobeying or failing to follow the reasonable directive of a supervisor to take action or cease actions which create a risk to the health or safety of a state employee or the public or threatens or intimidates them.

(3) Violation of this section shall constitute grounds for disciplinary action and referral for criminal prosecution.

Section 10. Issuance of Pay[~~Paychecks~~] to State Employees. (1) Pay[~~A paycheck~~] shall be issued to[~~a~~] state employees[~~employee~~] on the 15th and 30th day of each month.

(2) If the regularly scheduled pay date falls on a weekend, state employees shall be issued pay[~~a paycheck shall be issued~~] on the preceding Friday.

(3) If the regularly scheduled pay date falls on a state holiday as defined in KRS 18A.190, pay[~~a paycheck~~] shall be issued on the workday preceding the holiday.

Section 11. Incorporation by Reference. (1) “Personnel Action Notification”, PAN, August 2011, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Personnel Cabinet, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

TIM LONGMEYER, Cabinet Secretary

APPROVED BY AGENCY: May 14, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Monday, June 24, 2013 at 10:00 a.m. at 501 High Street, 3rd floor, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing 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 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 July 1, 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: Dinah T. Bevington, Office of Legal Services, 501 High Street, 3rd floor, Frankfort, Kentucky 40601, phone (502) 564-7430, fax (502) 564-0224.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Dinah T. Bevington

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation sets forth the requirements governing employee records, the maintenance and handling of these records, and other conditions of employment.

(b) The necessity of this administrative regulation: This administrative regulation is necessary for the oversight and maintenance of the state employment system pursuant to KRS Chapter 18A.

(c) How this administrative regulation conforms to the content of the authorizing statutes: Pursuant to 18A.030(2), the Personnel Cabinet Secretary is required to promulgate comprehensive regulations consistent with the provisions for KRS Chapter 18A.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation is necessary to satisfy the statutory requirement of establishing for the state a system of personnel administration based on merit principles. This regulation sets forth general terms and conditions of employment, to assist in the consistent application and treatment of KRS Chapter 18 employees. This regulation also applies to the unclassified service, pursuant to 101 KAR 3:050, Section 8.

(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 changes the references of "paycheck" to "pay", in order to properly codify the use of electronic fund transfers, commonly referred to as direct deposit, and other methods of payment.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to codify the use of other methods of payment.

(c) How the amendment conforms to the content of the authorizing statutes: These amendments are authorized pursuant to the authority provided in KRS 18A.110 and 18A.030(2), as the amendment addresses the manner by which employees are paid pursuant to the employee compensation plan.

(d) How the amendment will assist in the effective administration of the statutes: This amendment is necessary to codify the manner by which employees are compensated, to include electronic fund transfers and other methods of payment. The Commonwealth and employees have recognized that the use of paper paychecks results in increased administrative costs and, in some instances, delay in an employee’s receipt of pay. This amendment reflects the cost-effective and time-efficient payment alternatives that are available.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administra-

tive regulation: All KRS Chapter 18A employees and other individuals subject to the provisions of 101 KAR 2:095 will be affected.

(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: All actions which are required to comply with the amendments to the regulation have been taken by the Personnel Cabinet.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There are no additional costs anticipated to any entity identified above.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): No additional benefits will accrue that do not otherwise exist.

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

(a) Initially: This regulation, as amended, is not anticipated to generate any new or additional costs.

(b) On a continuing basis: This regulation, as amended, is not anticipated to generate any new or additional costs.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: This regulation, as amended, is not anticipated to generate any new or additional costs.

(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 regulation, as amended, is not anticipated to generate any new or additional fees or funding.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This regulation, as amended, is not anticipated to generate any new or additional fees.

(9) TIERING: Is tiering applied? No. This regulation, as amended, treats all impacted employees the same.

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? All state agencies with employees covered under KRS Chapter 18A.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 18A.030 (2), KRS 18A.110, and KRS Chapter 337.

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.

(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.

(c) How much will it cost to administer this program for the first year? There are no estimated additional costs to administer the amendments to this regulation.

(d) How much will it cost to administer this program for subsequent years? There are no estimated additional costs to administer the amendments within this 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:

PERSONNEL CABINET
Office of the Secretary
(Amendment)

101 KAR 2:102. Classified leave administrative regulations.

RELATES TO: KRS 18A.030, 18A.110, 18A.195, 61.394, 344.030, 29 U.S.C. 201 et. seq., 2601 et seq.

STATUTORY AUTHORITY: KRS 18A.030, 18A.110, 18A.155, 344.030, 29 U.S.C. 201 et seq., 2601 et seq.

NECESSITY, FUNCTION, AND CONFORMITY: KRS 18A.110(7)(g) requires the Secretary of Personnel, with the approval of the Governor, to promulgate administrative regulations which govern annual leave, sick leave, special leaves of absence, and other conditions of leave. This administrative regulation establishes the leave requirements for classified employees.

Section 1. Annual Leave. (1) Accrual of annual leave.

(a) Each full-time employee shall accumulate annual leave at the following rate:

Months of Service	Annual Leave Days
0-59 months	1 leave day per month; 12 per year
60-119 months	1 1/4 leave days per month; 15 per year
120-179 months	1 1/2 leave days per month; 18 per year
180-239 months	1 3/4 days per month; 21 per year
240 months & over	2 leave days per month; 24 per year

(b) A full-time employee shall have worked, or been on paid leave, other than educational leave with pay, for 100 or more regular hours per month to accrue annual leave.

(c) Accrued leave shall be credited on the first day of the month following the month in which the annual leave is earned.

(d) In computing months of total service for the purpose of earning annual leave, only the months for which an employee earned annual leave shall be counted.

(e) A former employee who has been rehired, except as provided in paragraph (f) of this subsection, shall receive credit for prior service, unless the employee had been dismissed as a result of misconduct or a violation of KRS 18A.140, 18A.145, or 18A.990.

(f) An employee, who has retired from a position covered by a state retirement system, is receiving retirement benefits, and returns to state service, shall not receive credit for months of service prior to retirement.

(g) A part-time employee shall not be entitled to annual leave.

(2) Use and retention of annual leave.

(a) Annual leave shall be used in increments of hours or one-quarter (1/4) hours.

(b) Except as provided in paragraph (c) of this subsection, an employee who makes a timely request for annual leave shall be granted annual leave by the appointing authority, during the calendar year, up to at least the amount of time earned that year, if the operating requirements of the agency permit.

(c) An appointing authority may require an employee who has a balance of at least 100 hours of compensatory leave to use compensatory leave before the employee's request to use annual leave is granted, unless the employee's annual leave balance exceeds the maximum number of hours that may be carried forward under this administrative regulation.

(d) Absence due to sickness, injury, or disability in excess of the amount available for those purposes shall, at the request of the employee, be charged against annual leave.

(e) An employee shall be able to use annual leave for an absence on a regularly scheduled workday.

(f) An employee who is transferred or otherwise moved from the jurisdiction of one (1) agency to another shall retain his accumulated annual leave in the receiving agency.

(g) An employee who is eligible for state contributions for life insurance under the provisions of KRS Chapter 18A shall have worked or been on paid leave, other than holiday or educational leave, during any part of the previous month.

(h) An employee who is eligible for state contributions for health benefits under the provisions of KRS Chapter18A shall have

worked or been on paid leave, other than holiday or educational leave, during any part of the previous pay period.

(i) Annual leave may be carried from one (1) calendar year to the next as provided in this paragraph:

Months of Service	Maximum Amount	37.5 Hour Week Equivalent	40 Hour Week Equivalent
0-59	30 workdays	225 hours	240 hours
60-119 months	37 workdays	277.50 hours	296 hours
120-179 months	45 workdays	337.50 hours	360 hours
180-239 months	52 workdays	390 hours	416 hours
240 months and over	60 workdays	450 hours	480 hours

(j) Leave in excess of the maximum amounts specified in paragraph (i) of this subsection shall be converted to sick leave at the end of the calendar year or upon retirement.

(k) The amount of annual leave that may be carried forward and the amount of annual leave that may be converted to sick leave shall be determined by computing months of service as provided by subsection (1)(d) of this section.

(3) Annual leave on separation.

(a)1. If an employee is separated by proper resignation or retirement, he shall be paid in a lump sum for accumulated annual leave.

2. The accumulated annual leave for which he is paid shall not exceed the amounts established by subsection (2)(i) of this section.

3. Following payment of annual leave at resignation, any remaining annual leave after the payment of the maximum shall:

a. Not be paid to the employee or converted to sick leave; and

b. Be removed from the balance.

(b) If an employee is laid off, he shall be paid in a lump sum for all accumulated annual leave.

(c) An employee in the unclassified service who reverts to the classified service, or resigns one (1) day and is employed the next workday, shall retain his accumulated leave in the receiving agency.

(d) An employee who has been dismissed for cause related to misconduct or who has failed, without proper excuse, to give proper notice of resignation or retirement shall not be paid for accumulated annual leave.

(e) Upon the death of an employee, his estate shall be entitled to receive pay for the unused portion of the employee's accumulated annual leave.

(f) An employee may request in writing that his accumulated annual leave not be paid upon resignation, and that all or part of the amount of his accumulated annual leave that does not exceed the amount established by this section be waived, if:

1. He resigns, or is laid off from his position, because of an approved plan of privatization of the services he performed; and

2. The successor employer has agreed to credit him with an equal amount of annual leave.

Section 2. Sick Leave. (1) Accrual of sick leave.

(a) An employee, except a part-time employee, shall accumulate sick leave with pay at the rate of one (1) working day per month.

(b) An employee shall have worked or been on paid leave, other than educational leave, for 100 or more regular hours in a month to accrue sick leave.

(c) An employee shall be credited with additional sick leave upon the first day of the month following the month in which the sick leave is earned.

(d) A full-time employee who completes 120 months of total service with the state shall be credited with ten (10) additional days of sick leave upon the first day of the month following the completion of 120 months of service.

(e) A full-time employee who completes 240 months of total service with the state shall be credited with another ten (10) additional days of sick leave upon the first day of the month following the completion of 240 months of service.

(f) In computing months of total service for the purpose of crediting sick leave, only the months for which an employee earned sick leave shall be counted.

(g) The total service shall be verified before the leave is credited to the employee's record.

(h) A former employee who has been rehired, except as provided in paragraph (i) of this subsection, shall receive credit for prior service, unless the employee had been dismissed as a result of misconduct or a violation of KRS 18A.140, 18A.145, or 18A.990.

(i) A former employee who is appointed, reinstated, or reemployed, other than a former employee receiving benefits under a state retirement system, shall be credited with the unused sick leave balance credited to him upon separation.

(j) Sick leave may be accumulated with no maximum.

(2) Use and retention of sick leave[~~with pay~~].

(a) An appointing authority shall grant or may require the use of sick leave with or without pay if an employee:

1. Is unable to work due to medical, dental, or optical examination or treatment;

2. Is disabled by illness or injury. The appointing authority may require the employee to provide a doctor's statement certifying the employee's inability to perform his duties for the days or hours sick leave is requested. The appointing authority may also require an employee to produce a certificate from an appropriate medical health professional certifying the employee's fitness to return to duty before the employee is permitted to return to work;

3. Is required to care for or transport a member of his immediate family in need of medical attention for a reasonable period of time. The appointing authority may require the employee to provide a doctor's statement certifying the employee's need to care for a family member; or

4. Would jeopardize the health of himself or others at his work station because of a contagious disease or demonstration of behavior that might endanger himself or others.

(b) At the termination of sick leave with pay, the appointing authority shall return the employee to his former position.

(c) An employee eligible for state contributions for life insurance under the provisions of KRS Chapter 18A shall have worked or been on paid leave, other than education leave, during any part of the previous month.

(d) An employee who is eligible for state contributions for health benefits under the provisions of KRS Chapter 18A shall have worked or been paid leave, other than educational leave, during any part of the previous pay period.

(e) Sick leave shall be used in increments of hours or one-quarter (1/4) hours.

(f) An employee who is transferred or otherwise moved from the jurisdiction of one (1) agency to another shall retain his accumulated sick leave in the receiving agency.

(g) An employee shall be credited for accumulated sick leave if he is separated by proper resignation, layoff, or retirement.

(3) Sick leave without pay.

(a) An appointing authority shall grant sick leave without pay, without a change in the employee's personnel status, for the duration of an employee's impairment by injury or illness, if:

1. The[~~total continuous~~] leave does not exceed thirty (30) calendar days[~~one (1) year~~]; and

2. The employee has used or been paid for all accumulated annual, sick, and compensatory leave unless he has requested to retain up to ten (10) days of accumulated sick leave.

(b) An appointing authority may grant sick leave without pay to an employee who does not qualify for family and medical leave due to lack of service time and who has exhausted all accumulated paid leave if the employee is required to care for a member of the immediate family for a period not to exceed thirty (30) working days.

(4) Sick leave by personnel action.

(a) If the duration of an employee's impairment by illness or injury exceeds the sick leave without pay allotment of thirty (30) calendar days, including holidays, the appointing authority shall place the employee on sick leave without pay by personnel action.

(b) The appointing authority shall notify the employee in writing that the employee is being placed on sick leave by personnel action.

(c) Sick leave by personnel action shall not exceed one (1) year.

(d)[~~For continuous leave without pay in excess of thirty (30) working days, excluding holidays, the appointing authority shall notify the employee in writing of the leave without pay status. (c)~~] The appointing authority may require periodic doctor's statements during the year attesting to the employee's continued inability to perform the essential functions of his duties with or without reasonable accommodation.[~~(d) An appointing authority may grant sick leave without pay to an employee who does not qualify for family and medical leave due to lack of service time and who has exhausted all accumulated paid leave if the employee is required to care for a member of the immediate family for a period not to exceed thirty (30) working days.~~]

(e) If an employee has given notice of his ability to resume his duties following sick leave by personnel action[~~without pay~~], the appointing authority shall return the employee to the original position or to a position for which he is qualified and which resembles his former position as closely as circumstances permit. The appointing authority shall notify the employee in writing of the following:

1. The effective date of the employee's return;

2. The position to which the employee is being returned; and

3. The employee's salary upon return to work.

(f) If reasonable accommodation is requested, the employee shall:

1. Inform the employer; and

2. Upon request, provide supportive documentation from a certified professional.

(g) An employee shall be deemed[~~considered to have~~] resigned if he:

1. Has been on one (1) year continuous sick leave by personnel action[~~without pay~~];

2. Has been requested by the appointing authority in writing to return to work at least ten (10) days prior to the expiration of[~~sick~~] leave;

3. Is unable to return to his former position;

4. Has been given priority consideration by the appointing authority for a vacant, budgeted position with the same agency, for which he is qualified and is capable of performing its essential functions with or without reasonable accommodation; and

5. Has not been placed by the appointing authority in a vacant position.

(h) Sick leave granted under this subsection shall not be renewable after the employee has been medically certified as able to return to work.

(i) An employee who is deemed[~~has been~~] resigned under paragraph (g) of this subsection shall retain reinstatement privileges that were accrued during service in the classified service.

(5)[~~(4)~~] Application for sick leave and supporting documentation.

(a) An employee shall file a written application for sick leave with or without pay within a reasonable time.

(b) Except for an emergency illness, an employee shall request advance approval for sick leave for medical, dental, or optical examinations, and for sick leave without pay.

(c) If the employee is too ill to work, an employee shall notify the immediate supervisor or other designated person. Failure, without good cause, to do so in a reasonable period of time shall be cause for denial of sick leave for the period of absence.

(d) An appointing authority may, for good cause and on notice, require an employee to supply supporting evidence in order to receive sick leave.

(e) A medical certificate may be required, signed by a licensed practitioner and certifying to the employee's incapacity, examination, or treatment.

(f) An appointing authority shall grant sick leave if the application is supported by acceptable evidence but may require confirmation if there is reasonable cause to question the authenticity of the certificate or its contents.

Section 3. Family and Medical Leave. (1) An appointing authority shall comply with the requirements of the Family and Medical Leave Act (FMLA) of 1993, 29 U.S.C. 2601 et seq., and the federal regulations implementing the Act, 29 C.F.R. Part 825.

(2) An employee in state service shall qualify for twelve (12) weeks of unpaid family leave if the employee has:

(a) Completed twelve (12) months of service; and

(b) Worked or been on paid leave at least 1,250 hours in the twelve (12) months immediately preceding the first day of family and medical leave.

(3) Family and medical leave shall be awarded on a calendar year basis.

(4) An employee shall be entitled to a maximum of twelve (12) weeks of unpaid family and medical leave for the birth, placement, or adoption of the employee's child.

(5) While an employee is on unpaid family and medical leave, the state contribution for health and life insurance shall be maintained by the employer.

(6) If the employee would qualify for family and medical leave, but has an annual, compensatory, or sick leave balance, upon the employee's request, the agency shall permit:

(a) The employee to reserve ten (10) days of accumulated sick leave and be placed on FMLA leave; or

(b) The employee to use accrued paid leave concurrently with FMLA leave.

Section 4. Court Leave. (1) An employee shall be entitled to court leave during his scheduled working hours without loss of time or pay for the amount of time necessary to:

(a) Comply with a subpoena by a court, administrative agency, or body of the federal or state government or any political subdivision thereof; or

(b) Serve as a juror or a witness, unless the employee or a member of his family is a party to the proceeding.

(2) Court leave shall include necessary travel time.

(3) If relieved from duty as a juror or witness during his normal working hours, the employee shall return to work or use annual or compensatory leave.

(4) An employee shall not be required to report as court leave attendance at a proceeding that is part of his assigned duties.

Section 5. Compensatory Leave and Overtime. (1) Accrual of compensatory leave and overtime.

(a) An appointing authority shall comply with the overtime and compensatory leave provisions of the Fair Labor Standards Act (FLSA), 29 U.S.C. Chapter 8.

(b) An employee who is directed to work, or who requests and is authorized to work, in excess of the prescribed hours of duty shall be granted compensatory leave and paid overtime subject to the provisions of the Fair Labor Standards Act, the Kentucky Revised Statutes, and this administrative regulation.

(c) An employee deemed to be "nonexempt" by the provisions of the FLSA shall be compensated for hours worked in excess of forty (40) per week as provided by subparagraphs 1 to 3 of this paragraph.

1. An employee who has not accumulated the maximum amount of compensatory leave shall have the option to accumulate compensatory leave at the rate of an hour and one-half (1 1/2) for each hour worked in excess of forty (40) per week in lieu of paid overtime.

2. The election to receive compensatory leave in lieu of paid overtime shall be in writing on the Overtime Compensation Form and shall remain in force for a minimum of three (3)[~~six (6)~~] months. The election shall be changed by the submission of a new form. The effective date of a change shall be the first day of the next work week following receipt of the election.

3. An employee who does not elect compensatory leave in lieu of paid overtime shall be paid one and one-half (1 1/2) times the regular hourly rate of pay for all hours worked in excess of forty (40) hours per week.

(d) An employee deemed to be "exempt" under the provisions of the FLSA shall accumulate compensatory time on an hour-for-hour basis for hours worked in excess of the regular work schedule.

(e) Compensatory leave shall be accumulated or taken off in one-quarter (1/4) hour increments.

(f) The maximum amount of compensatory leave that may be carried forward from one (1) pay period to another shall be:

1. 239.99 hours by an employee in a non policy-making position; or

2. 240 hours by an employee in a policy-making position.

(g) An employee who is transferred or otherwise moved from the jurisdiction of one (1) agency to another shall retain the compensatory leave in the receiving agency.

(2) Reductions in compensatory leave balances.

(a) An appointing authority may require an employee who has accrued at least 100 hours compensatory leave to use compensatory leave before annual leave and shall otherwise allow the use of compensatory leave if it will not unduly disrupt the operations of the agency.

(b) An appointing authority may require an employee who has accrued 200 hours of compensatory leave to take off work using compensatory leave in an amount sufficient to reduce the compensatory leave balance below 200 hours.

(c) An employee who is not in a policy-making position may, after accumulating 151 hours of compensatory leave, request payment for fifty (50) hours at the regular rate of pay. If the appointing authority or the designee approves the payment, an employee's leave balance shall be reduced accordingly.

(d) An employee who is not in a policy-making position shall be paid for fifty (50) hours at the regular hourly rate of pay, upon accumulating at the end of the pay period, 240 hours of compensatory leave. The employee's leave balance shall be reduced accordingly.

(e) If an employee's prescribed hours of duty are normally less than forty (40) hours per week, the employee shall receive compensatory leave for the number of hours worked that:

1. Exceed the number of normally prescribed hours of duty; and

2. Do not exceed the maximum amount of compensatory time that is permitted.

(f) Only hours actually worked shall be used for computing paid overtime or time and one-half (1 1/2) compensatory time.

(g) Upon separation from state service, an employee shall be paid for all unused compensatory leave at the greater of his:

1. Regular hourly rate of pay; or

2. Average regular rate of pay for the final three (3) years of employment.

Section 6. Military Leave. (1) Upon request, an employee who is an active member of the United States Army Reserve, the United States Air Force Reserve, the United States Naval Reserve, the United States Marine Corps Reserve, the United States Coast Guard Reserve, the United States Public Health Service Reserve, or the Kentucky National Guard shall be relieved from the civil duties, to serve under order or training duty without loss of the regular compensation for a period not to exceed the number of working days specified in KRS 61.394 for a federal fiscal year.

(2) The absence shall not be charged to leave.

(3) Absence that exceeds the number of working days specified in KRS 61.394 for a federal fiscal year shall be charged to annual leave, compensatory leave, or leave without pay.

(4) The appointing authority may require a copy of the orders requiring the attendance of the employee before granting military leave.

(5) An appointing authority shall grant an employee entering military duty a leave of absence without pay for the period of duty in accordance with KRS 61.373[~~not to exceed six (6) years~~]. Upon receiving military duty leave of absence, all accumulated annual and compensatory leave shall be paid in a lump sum, if requested by the employee.

Section 7. Voting and Election Leave. (1) An employee who is eligible and registered to vote shall be allowed, upon prior request and approval, four (4) hours, for the purpose of voting.

(2) An election officer shall receive additional leave if the total leave for election day does not exceed a regular workday.

(3) The absence shall not be charged against leave.

(4) An employee who is permitted or required to work during the employee's regular work hours, in lieu of voting leave, shall be granted compensatory leave on an hour-for-hour basis for the hours during the times the polls are open, up to a maximum of four (4) hours.

Section 8. Funeral and Bereavement Leave. (1) Upon the approval of the appointing authority, an employee who has lost an immediate family member by death may utilize three (3) days of accrued sick leave, compensatory leave, annual leave, or leave without pay if the employee does not have accrued leave, or a combination thereof.

(2) An appointing authority may approve the use of additional sick leave, compensatory leave, annual leave, or leave without pay if the employee does not have accrued leave, or a combination thereof, at the request of the employee following the loss of an immediate family member.

(3) For purposes of funeral and bereavement leave, an immediate family member shall include the employee's spouse, parent, grandparent, child, brother, or sister, or the spouse of any of them, and may include other relatives of close association if approved by the appointing authority.

Section 9. Special Leave of Absence. (1) If approved by the secretary, an appointing authority may grant a leave of absence for continuing education or training.

(a) Leave may be granted for a period not to exceed twenty-four (24) months.

(b) If granted, leave shall be granted either with pay (if the employee contractually agrees to a service commitment) or without pay.

(c) Leave shall be restricted to attendance at a college, university, vocational, or business school for training in subjects that relate to the employee's work and will benefit the state.

(2) An appointing authority, with approval of the secretary, may grant an employee a leave of absence without pay for a period not to exceed one (1) year for purposes other than specified in this administrative regulation that are of tangible benefit to the state.

(3) If approved by the secretary, an appointing authority may place an employee on special leave with pay for investigative purposes pending an investigation of an allegation of employee misconduct.

(a) Leave shall not exceed sixty (60) working days.

(b) The employee shall be notified in writing by the appointing authority that he is being placed on special leave for investigative purposes, and the reasons for being placed on leave.

(c) If the investigation reveals no misconduct by the employee, records relating to the investigation shall be purged from agency and Personnel Cabinet files.

(d) The appointing authority shall notify the employee, in writing, of the completion of the investigation and the action taken. This notification shall be made to the employee, whether the employee has remained in state service, or has voluntarily resigned after being placed on special leave for investigative purposes.

Section 10. Absence Without Leave. (1) An employee who is absent from duty without prior approval shall report the reason for the absence to the supervisor immediately.

(2) Unauthorized or unreported absence shall:

(a) Be considered absence without leave;

(b) Be treated as leave without pay for an employee covered by the provisions of the Fair Labor Standards Act; and

(c) Constitute grounds for disciplinary action.

(3) An employee who has been absent without leave or notice to the supervisor for a period of ten (10) working days shall be considered to have resigned the employment.

Section 11. Absences Due to Adverse Weather. (1) An employee, who is not designated for mandatory operations and chooses not to report to work or chooses to leave early in the event of adverse weather conditions such as tornado, flood, blizzard, or ice storm, shall have the time of the absence reported as:

(a) Charged to annual or compensatory leave;

(b) Taken as leave without pay, if annual and compensatory

leave has been exhausted; or

(c) Deferred in accordance with subsections (3) and (4) of this section.

(2) An employee who is on prearranged annual, compensatory, or sick leave shall charge leave as originally requested.

(3) If operational needs allow, except for an employee in mandatory operations, management shall make every reasonable effort to arrange schedules whereby an employee will be given an opportunity to make up time not worked rather than charging it to leave.

(4) An employee shall not make up work if the work would result in the employee working more than forty (40) hours in a workweek.

(a) Time lost shall be made up within four (4) months of the occurrence of the absence. If it is not made up within four (4) months, annual or compensatory leave shall be deducted to cover the absence, or leave without pay shall be charged if no annual or compensatory leave is available.

(b) If an employee transfers or separates from employment before the leave is made up, the leave shall be charged to annual or compensatory leave or deducted from the final paycheck.

(5) If catastrophic, life-threatening weather conditions occur, as created by a tornado, flood, ice storm, or blizzard, and it becomes necessary for authorities to order evacuation or shutdown of the place of employment, the following provisions shall apply:

(a) An employee who is required to evacuate or who would report to a location that has been shutdown shall not be required to make up the time that is lost from work during the period officially declared hazardous to life and safety; and

(b) An employee who is required to work in an emergency situation shall be compensated pursuant to the provisions of Section 5 of this administrative regulation and the Fair Labor Standards Act as amended.

Section 12. Blood Donation Leave. (1) An employee who, during regular working hours, donates blood at a licensed blood center certified by the Food and Drug Administration shall receive four (4) hours leave time, with pay, for the purpose of donating and recuperating from the donation.

(2) Leave granted under this section shall be used at the time of the donation unless circumstances as specified by the supervisor required the employee to return to work. If the employee returns to work, the unused portion of the leave time shall be credited as compensatory leave.

(3) An employee shall request leave in advance to qualify for blood donation leave.

(4) An employee who is deferred from donating blood shall not:

(a) Be charged leave time for the time spent in the attempted donation; and

(b) Qualify for the remainder of the blood donation leave.

Section 13. Incorporation by Reference. (1) "Overtime Compensation Form", May 2013[~~March 2011~~], is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Personnel Cabinet, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

TIM LONGMEYER, Cabinet Secretary

APPROVED BY AGENCY: May 14, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Monday, June 24, 2013 at 10:30 a.m. at 501 High Street, 3rd Floor, Conference Room, 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 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 July 1, 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: Dinah T. Bevington, Executive Director, Office of Legal Services, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601, phone (502) 564-7430, fax (502) 564-0224.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Dinah T. Bevington

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation details the various types of classified leave available to state employees.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the various types of leave available for state classified employees, and the requirements for these types of leave.

(c) How this administrative regulation conforms to the content of the authorizing statutes: Pursuant to 18A.030(2), the Personnel Cabinet Secretary is required to promulgate comprehensive regulations consistent with the provisions for KRS Chapter 18A. KRS 18A.110(7)(g) requires the Secretary of Personnel, with the approval of the Governor, to promulgate administrative regulations which govern annual leave, sick leave, special leaves of absence, and other conditions of leave.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation assists in the consistent application and treatment for classified employees on all employment leave matters.

(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 amendments clarify that holiday pay does not count towards service time to qualify for the health and life insurance state contributions. Additionally, the amendments clarify the handling of sick leave without pay. The amendments also include the ability for employees to change the election of compensatory leave in lieu of overtime pay every three (3) months rather than every six (6) months. The amendments clarify that military leave shall be consistent with the time provided in KRS 61.373. Finally, the amendments remove the language "with pay" from the title of a provision, which also permits the use of unpaid sick leave in certain instances.

(b) The necessity of the amendment to this administrative regulation: These amendments are necessary to ensure the consistent application and handling of sick leave without pay and military leave. These amendments are also necessary to document the process by which an employee's overtime election can be changed. Finally, the amendments address typographical errors currently located within the regulation.

(c) How the amendment conforms to the content of the authorizing statutes: Pursuant to 18A.030(2), the Personnel Cabinet Secretary is required to promulgate comprehensive regulations consistent with the provisions for KRS Chapter 18A. KRS 18A.110(7)(g) requires the Secretary of Personnel, with the approval of the Governor, to promulgate administrative regulations which govern annual leave, sick leave, special leaves of absence, and other conditions of leave. These amendments clarify the processes and handling of employee leave, which is authorized pursuant to the statutes cited herein.

(d) How the amendment will assist in the effective administration of the statutes: These amendments are necessary to ensure the consistent application and handling of employee leave.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All KRS Chapter 18A classified employees and other individuals subject to the provisions of 101 KAR 2:102 will be affected.

(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: All actions which are required to comply with the amendments to the regulation have been taken by the Personnel Cabinet.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): No additional benefits will accrue that do not otherwise exist.

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

(a) Initially: This regulation, as amended, is not anticipated to generate any new or additional costs.

(b) On a continuing basis: This regulation, as amended, is not anticipated to generate any new or additional costs.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: This regulation, as amended, is not anticipated to generate any new or additional costs.

(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 regulation, as amended, is not anticipated to generate any new or additional fees or funding.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This regulation, as amended, is not anticipated to generate any new or additional fees.

(9) TIERING: Is tiering applied? No. All KRS Chapter 18A classified employees and other individuals subject to the provisions of 101 KAR 2:102 are treated the same.

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? All state agencies with employees covered under KRS Chapter 18A are impacted.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 18A.030(2) and KRS 18A.110(7)(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 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.

(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.

(c) How much will it cost to administer this program for the first year? There are no estimated additional costs to administer the amendments within this regulation.

(d) How much will it cost to administer this program for subsequent years? There are no estimated additional costs to administer the amendments within this 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:

PERSONNEL CABINET
Office of the Secretary
(Amendment)

101 KAR 3:015. Leave administrative regulations for the unclassified service.

RELATES TO: KRS 18A.030, 18A.110, 18A.195, 61.394, 344.030, 29 U.S.C. 201 et. seq., 2601 et seq.

STATUTORY AUTHORITY: KRS 18A.030, 18A.110, 18A.155, 344.030, 29 U.S.C. 201 et seq., 2601 et seq.

NECESSITY, FUNCTION, AND CONFORMITY: KRS 18A.110(7)(g) requires the Secretary of Personnel, with the approval of the Governor, to promulgate administrative regulations which govern annual leave, sick leave, special leaves of absence, and other conditions of leave. This administrative regulation establishes the leave requirements for unclassified employees.

Section 1. Annual Leave. (1) Accrual of annual leave.

(a) Each full-time employee shall accumulate annual leave at the following rate:

Months of Service	Annual Leave Days
0-59 months	1 leave day per month; 12 per year
60-119 months	1 1/4 leave days per month; 15 per year
120-179 months	1 1/2 leave days per month; 18 per year
180-239 months	1 3/4 days per month; 21 per year
240 months & over	2 leave days per month; 24 per year

(b) A full-time employee shall have worked, or been on paid leave, other than educational leave with pay, for 100 or more regular hours per month to accrue annual leave.

(c) Accrued leave shall be credited on the first day of the month following the month in which the annual leave is earned.

(d) In computing months of total service for the purpose of earning annual leave, only the months for which an employee earned annual leave shall be counted.

(e) A former employee who has been rehired, except as provided in paragraph (f) of this subsection, shall receive credit for prior service, unless the employee had been dismissed as a result of misconduct or a violation of KRS 18A.140, 18A.145, or 18A.990.

(f) An employee, who has retired from a position covered by a state retirement system, is receiving retirement benefits, and returns to state service, shall not receive credit for months of service prior to retirement.

(g) A part-time or interim employee shall not be entitled to annual leave.

(2) Use and retention of annual leave.

(a) Annual leave shall be used in increments of hours or one-quarter (1/4) hours.

(b) Except as provided in paragraph (c) of this subsection, an employee who makes a timely request for annual leave shall be granted annual leave by the appointing authority, during the calendar year, up to at least the amount of time earned that year, if the operating requirements of the agency permit.

(c) An appointing authority may require an employee who has a balance of at least 100 hours of compensatory leave to use compensatory leave before the employee's request to use annual leave is granted, unless the employee's annual leave balance exceeds the maximum number of hours that may be carried forward under this administrative regulation.

(d) Absence due to sickness, injury, or disability in excess of the amount available for those purposes shall, at the request of the employee, be charged against annual leave.

(e) An employee shall be able to use annual leave for an absence on a regularly scheduled workday.

(f) An employee who is transferred or otherwise moved from the jurisdiction of one (1) agency to another shall retain accumulated annual leave in the receiving agency.

(g) An employee who is eligible for state contributions for life insurance under the provisions of KRS Chapter 18A shall have worked or been on paid leave, other than holiday or educational leave, during any part of the previous month.

(h) An employee who is eligible for state contributions for health benefits under the provisions of KRS Chapter 18A shall

have worked or been on paid leave, other than holiday or educational leave, during any part of the previous pay period.

(i) Annual leave may be carried from one (1) calendar year to the next as provided in this paragraph:

Months of Service	Maximum Amount	37.5 hour week equivalent	40 hour week equivalent
0-59	30 workdays	225 hours	240 hours
60-119 months	37 workdays	277.50 hours	296 hours
120-179 months	45 workdays	337.50 hours	360 hours
180-239 months	52 workdays	390 hours	416 hours
240 months and over	60 workdays	450 hours	480 hours

(j) Leave in excess of the maximum amounts specified in paragraph (i) of this subsection shall be converted to sick leave at the end of the calendar year or upon retirement.

(k) The amount of annual leave that may be carried forward and the amount of annual leave that may be converted to sick leave shall be determined by computing months of service as provided by subsection (1)(d) of this section.

(3) Annual leave on separation.

(a)1. If an employee is separated by proper resignation or retirement, he shall be paid in a lump sum for accumulated annual leave.

2. The accumulated annual leave for which he is paid shall not exceed the amounts established by subsection (2)(i) of this section.

3. Following payment of annual leave at resignation, any remaining annual leave after the payment of the maximum shall:

a. Not be paid to the employee or converted to sick leave; and

b. Be removed from the balance.

(b) If an employee is laid off, he shall be paid in a lump sum for all accumulated annual leave.

(c) An employee in the unclassified service who reverts to the classified service, or resigns or is terminated one (1) day and is employed the next workday, shall retain his accumulated leave in the receiving agency.

(d) An employee who has been dismissed for cause related to misconduct or who has failed, without proper excuse, to give proper notice of resignation or retirement shall not be paid for accumulated annual leave.

(e) Upon the death of an employee, his estate shall be entitled to receive pay for the unused portion of the employee's accumulated annual leave.

(f) An employee may request in writing that his accumulated annual leave not be paid upon resignation, and that all or part of the amount of his accumulated annual leave that does not exceed the amount established by this section be waived, if:

1. He resigns, or is laid off from his position, because of an approved plan of privatization of the services he performed; and

2. The successor employer has agreed to credit him with an equal amount of annual leave.

Section 2. Sick Leave. (1) Accrual of sick leave.

(a) An employee, except a part-time employee, shall accumulate sick leave with pay at the rate of one (1) working day per month.

(b) An employee shall have worked or been on paid leave, other than educational leave, for 100 or more regular hours in a month to accrue sick leave.

(c) An employee shall be credited with additional sick leave upon the first day of the month following the month in which the sick leave is earned.

(d) A full-time employee who completes 120 months of total service with the state shall be credited with ten (10) additional days of sick leave upon the first day of the month following the completion of 120 months of service.

(e) A full-time employee who completes 240 months of total service with the state shall be credited with another ten (10) additional days of sick leave upon the first day of the month following the completion of 240 months of service.

(f) In computing months of total service for the purpose of crediting sick leave, only the months for which an employee earned sick leave shall be counted.

(g) The total service shall be verified before the leave is credited to the employee's record.

(h) A former employee who has been rehired, except as provided in paragraph (i) of this subsection, shall receive credit for prior service, unless the employee had been dismissed as a result of misconduct or a violation of KRS 18A.140, 18A.145, or 18A.990.

(i) A former employee, other than a former employee receiving benefits under a state retirement system, who is appointed to an unclassified position, shall be credited with the unused sick leave balance upon separation.

(j) Sick leave may be accumulated with no maximum.

(2) Use and retention of sick leave [~~with pay~~].

(a) An appointing authority shall grant or may require the use of[~~accrued~~] sick leave with or without pay if an employee:

1. Is unable to work due to medical, dental, or optical examination or treatment;

2. Is disabled by illness or injury. The appointing authority may require the employee to provide a doctor's statement certifying the employee's inability to perform his duties for the days or hours sick leave is requested. The appointing authority may also require an employee to produce a certificate from an appropriate medical health professional certifying the employee's fitness to return to duty before the employee is permitted to return to work;

3. Is required to care for or transport a member of his immediate family in need of medical attention for a reasonable period of time. The appointing authority may require the employee to provide a doctor's statement certifying the employee's need to care for a family member; or

4. Would jeopardize the health of himself or others at his work station because of a contagious disease or demonstration of behavior that might endanger himself or others.

(b) At the termination of sick leave with pay, the appointing authority shall return the employee to his former position.

(c) An employee eligible for state contributions for life insurance under the provisions of KRS Chapter 18A shall have worked or been on paid leave, other than education leave, during any part of the previous month.

(d) An employee who is eligible for state contributions for health benefits under the provisions of KRS Chapter 18A shall have worked or been on paid leave, other than educational leave, during any part of the previous pay period.

(e) Sick leave shall be used in increments of hours or one-quarter (1/4) hours.

(f) An employee who is transferred or otherwise moved from the jurisdiction of one (1) agency to another shall retain his accumulated sick leave in the receiving agency.

(g) An employee shall be credited for accumulated sick leave if he is separated by proper resignation, layoff, or retirement.

(h) The duration of an interim employee's appointment shall not be extended by the use or approval for sick leave with or without pay.

(3) Sick leave without pay.

(a) An appointing authority shall grant sick leave without pay, without a change in the employee's personnel status,[~~to an employee~~] for the duration of an employee's impairment by injury or illness, if:

1. The[~~total continuous~~] leave does not exceed thirty (30) calendar days[~~one (1) year~~]; and

2. The employee has used or been paid for all accumulated annual, sick, and compensatory leave unless he has requested to retain up to ten (10) days of accumulated sick leave.

(b) An appointing authority may grant sick leave without pay to an employee who does not qualify for family and medical leave due to lack of service time and who has exhausted all accumulated paid leave if the employee is required to care for a member of the immediate family for a period not to exceed thirty (30) working days.

(4) Sick leave by personnel action.

(a) If the duration of an employee's impairment by illness or injury exceeds the sick leave without pay allotment of thirty (30) calendar days, including holidays, the appointing authority shall

place the employee on sick leave without pay by personnel action.

(b) The appointing authority shall notify the employee in writing that the employee is being placed on sick leave by personnel action.

(c) Sick leave by personnel action shall not exceed one (1) year.

(d)[~~For continuous leave without pay in excess of thirty (30) working days, excluding holidays, the appointing authority shall notify the employee in writing of the leave without pay status. (c)~~] The appointing authority may require periodic doctor's statements during the year attesting to the employee's continued inability to perform the essential functions of his duties with or without reasonable accommodation.[~~(d) An appointing authority may grant sick leave without pay to an employee who does not qualify for family and medical leave due to lack of service time and who has exhausted all accumulated paid leave if the employee is required to care for a member of the immediate family for a period not to exceed thirty (30) working days.~~]

(e) If an employee has given notice of his ability to resume his duties following sick leave by personnel action[~~without pay~~], the appointing authority shall return the employee to the original position or to a position for which he is qualified and which resembles his former position as closely as circumstances permit. The appointing authority shall notify the employee in writing of the following:

1. The effective date of the employee's return;

2. The position to which the employee is being returned; and

3. The employee's salary upon return to work.

(f) If reasonable accommodation is requested, the employee shall:

1. Inform the employer; and

2. Upon request, provide supportive documentation from a certified professional.

(g) An employee shall be deemed[~~considered to have~~] resigned if he:

1. Has been on one (1) year continuous sick leave by personnel action[~~without pay~~];

2. Has been requested by the appointing authority in writing to return to work at least ten (10) days prior to the expiration of[~~sick~~] leave;

3. Is unable to return to his former position;

4. Has been given priority consideration by the appointing authority for a vacant, budgeted position with the same agency, for which he is qualified and is capable of performing its essential functions with or without reasonable accommodation; and

5. Has not been placed by the appointing authority in a vacant position.

(h) Sick leave granted under this subsection shall not be renewable after the employee has been medically certified as able to return to work.

(i) An employee who is deemed[~~has been~~] resigned under paragraph (g) of this subsection shall retain reinstatement privileges that were accrued during[~~his~~] service in the classified service.

(5)[~~(4)~~] Application for sick leave and supporting documentation.

(a) An employee shall file a written application for sick leave with or without pay within a reasonable time.

(b) Except for an emergency illness, an employee shall request advance approval for sick leave for medical, dental, or optical examinations, and for sick leave without pay.

(c) If he is too ill to work, an employee shall notify his immediate supervisor or other designated person. Failure, without good cause, to do so in a reasonable period of time shall be cause for denial of sick leave for the period of absence.

(d) An appointing authority may, for good cause and on notice, require an employee to supply supporting evidence in order to receive sick leave.

(e) A medical certificate may be required, signed by a licensed practitioner and certifying to the employee's incapacity, examination, or treatment.

(f) An appointing authority shall grant sick leave if the application is supported by acceptable evidence but may require confirmation if there is reasonable cause to question the authenticity of the certificate or its contents.

Section 3. Family and Medical Leave. (1) An appointing authority shall comply with the requirements of the Family and Medical Leave Act (FMLA) of 1993, 20 U.S.C. 2601 et seq., and the federal regulations implementing the Act, 29 C.F.R. Part 825.

(2) An employee in state service shall qualify for twelve (12) weeks of unpaid family leave if the employee has:

(a) Completed twelve (12) months of service; and

(b) Worked or been on paid leave at least 1,250 hours in the twelve (12) months immediately preceding the first day of family and medical leave.

(3) Family and medical leave shall be awarded on a calendar year basis.

(4) An employee shall be entitled to a maximum of twelve (12) weeks of unpaid family and medical leave for the birth, placement, or adoption of the employee's child.

(5) While an employee is on unpaid family and medical leave, the state contribution for health and life insurance shall be maintained by the employer.

(6) If the employee would qualify for family and medical leave, but has an annual, compensatory, or sick leave balance, the agency shall not designate the leave as FMLA leave until:

(a) The employee's leave balance has been exhausted; or

(b) The employee requests to reserve ten (10) days of accumulated sick leave and be placed on unpaid FMLA leave.

Section 4. Court Leave. (1) An employee shall be entitled to court leave during his scheduled working hours without loss of time or pay for the amount of time necessary to:

(a) Comply with a subpoena by a court, administrative agency, or body of the federal or state government or any political subdivision thereof; or

(b) Serve as a juror or a witness, unless the employee or a member of his family is a party to the proceeding.

(2) Court leave shall include necessary travel time.

(3) If relieved from duty as a juror or witness during his normal working hours, the employee shall return to work or use annual or compensatory leave.

(4) An employee shall not be required to report as court leave attendance at a proceeding that is part of his assigned duties.

Section 5. Compensatory Leave and Overtime. (1) Accrual of compensatory leave and overtime.

(a) An appointing authority shall comply with the overtime and compensatory leave provisions of the Fair Labor Standards Act (FLSA), 29 U.S.C. Chapter 8.

(b) An employee who is directed to work, or who requests and is authorized to work, in excess of the prescribed hours of duty shall be granted compensatory leave and paid overtime subject to the provisions of the Fair Labor Standards Act, the Kentucky Revised Statutes, and this administrative regulation.

(c) An employee deemed to be "nonexempt" by the provisions of the FLSA shall be compensated for hours worked in excess of forty (40) per week as provided by subparagraphs 1 to 3 of this paragraph.

1. An employee who has not accumulated the maximum amount of compensatory leave shall have the option to accumulate compensatory leave at the rate of an hour and one-half (1 1/2) for each hour worked in excess of forty (40) per week in lieu of paid overtime.

2. The election to receive compensatory leave in lieu of paid overtime shall be in writing on the Overtime Compensation Form and shall remain in force for a minimum of three (3)[~~six (6)~~] months. The election shall be changed by the submission of a new form. The effective date of a change shall be the first day of the next workweek following receipt of the election.

3. An employee who does not elect compensatory leave in lieu of paid overtime shall be paid one and one-half (1 1/2) times his regular hourly rate of pay for all hours worked in excess of forty (40) hours per week.

(d) An employee deemed to be "exempt" under the provisions of the FLSA shall accumulate compensatory time on an hour-for-hour basis for hours worked in excess of his regular work schedule.

(e) Compensatory leave shall be accumulated or taken off in

one-quarter (1/4) hour increments.

(f) The maximum amount of compensatory leave that may be carried forward from one (1) pay period to another shall be;

1. 239.99 hours by an employee in a non policy-making position; or

2. 240 hours by an employee in a policy-making position.

(g) An employee who is transferred or otherwise moved from the jurisdiction of one (1) agency to another shall retain his compensatory leave in the receiving agency.

(2) Reductions in compensatory leave balances.

(a) An appointing authority may require an employee who has accrued at least 100 hours compensatory leave to use compensatory leave before annual leave and shall otherwise allow the use of compensatory leave if it will not unduly disrupt the operations of the agency.

(b) An appointing authority may require an employee who is not in a policy-making position and has accrued 200 hours of compensatory leave to take off work using compensatory leave in an amount sufficient to reduce the compensatory leave balance below 200 hours.

(c) An employee who is not in a policy-making position may, after accumulating 151 hours of compensatory leave, request that he be paid for fifty (50) hours at his regular rate of pay. If the appointing authority or his designee approves the payment, an employee's leave balance shall be reduced accordingly.

(d) An employee who is not in a policy-making position shall be paid for fifty (50) hours at his regular hourly rate of pay, upon accumulating at the end of the pay period, 240 hours of compensatory leave. The employee's leave balance shall be reduced accordingly.

(e) If an employee's prescribed hours of duty are normally less than forty (40) hours per week, he shall receive compensatory leave for the number of hours worked that:

1. Exceed the number of normally prescribed hours of duty; and

2. Do not exceed the maximum amount of compensatory time that is permitted.

(f) Only hours actually worked shall be used for computing paid overtime or time and one-half (1 1/2) compensatory time.

(g) Upon separation from state service, an employee shall be paid for all unused compensatory leave at the greater of his:

1. Regular hourly rate of pay; or

2. Average regular rate of pay for the final three (3) years of employment.

Section 6. Military Leave. (1) Upon request, an employee who is an active member of the United States Army Reserve, the United States Air Force Reserve, the United States Naval Reserve, the United States Marine Corps Reserve, the United States Coast Guard Reserve, the United States Public Health Service Reserve, or the Kentucky National Guard shall be relieved from his civil duties, to serve under order on training duty without loss of his regular compensation for a period not to exceed the number of working days specified in KRS 61.394 for a federal fiscal year.

(2) The absence shall not be charged to leave.

(3) Absence that exceeds the number of working days specified in KRS 61.394 for a federal fiscal year shall be charged to annual leave, compensatory leave, or leave without pay.

(4) The appointing authority may require a copy of the orders requiring the attendance of the employee before granting military leave.

(5) An appointing authority shall grant an employee entering military duty a leave of absence without pay for the period of duty in accordance with KRS 61.373[~~not to exceed six (6) years~~]. Upon receiving military duty leave of absence, all accumulated annual and compensatory leave shall be paid in a lump sum, if requested by the employee.

Section 7. Voting and Election Leave. (1) An employee who is eligible and registered to vote shall be allowed, upon prior request and approval, four (4) hours, for the purpose of voting.

(2) An election officer shall receive additional leave if the total leave for election day does not exceed a regular workday.

(3) The absence shall not be charged against leave.

(4) An employee who is permitted or required to work during the employee's regular work hours, in lieu of voting leave, shall be granted compensatory leave on an hour-for-hour basis for the hours during the times the polls are open, up to a maximum of four (4) hours.

Section 8. Funeral and Bereavement Leave. (1) Upon the approval of the appointing authority, an employee who has lost an immediate family member by death may utilize three (3) days of accrued sick leave, compensatory leave, annual leave, or leave without pay if the employee does not have accrued leave, or a combination thereof.

(2) An appointing authority may approve the use of additional sick leave, compensatory leave, annual leave, or leave without pay if the employee does not have accrued leave, or a combination thereof, at the request of the employee following the loss of an immediate family member.

(3) For purposes of funeral and bereavement leave, an immediate family member shall include the employee's spouse, parent, grandparent, child, brother, or sister, or the spouse of any of them, and may include other relatives of close association if approved by the appointing authority.

Section 9. Special Leave of Absence. (1) If approved by the secretary, an appointing authority may grant a leave of absence for continuing education or training.

(a) Leave may be granted for a period not to exceed twenty-four (24) months or the conclusion of the administration in which the employee is serving, whichever comes first.

(b) If granted, leave shall be granted either with pay (if the employee contractually agrees to a service commitment) or without pay.

(c) Leave shall be restricted to attendance at a college, university, vocational, or business school for training in subjects that relate to the employee's work and will benefit the state.

(2) An appointing authority, with approval of the secretary, may grant an employee a leave of absence without pay for a period not to exceed one (1) year for purposes other than specified in this administrative regulation that are of tangible benefit to the state.

(3)(a) If approved by the secretary, an appointing authority may place an employee on special leave with pay for investigative purposes pending an investigation of an allegation of employee misconduct.

(b) Leave shall not exceed sixty (60) working days.

(c) The employee shall be notified in writing by the appointing authority that he is being placed on special leave for investigative purposes, and the reasons for being placed on leave.

(d) If the investigation reveals no misconduct by the employee, records relating to the investigation shall be purged from agency and Personnel Cabinet files.

(e) The appointing authority shall notify the employee, in writing, of the completion of the investigation and the action taken. This notification shall be made to the employee, whether he has remained in state service, or has voluntarily resigned after being placed on special leave for investigative purposes.

Section 10. Absence Without Leave. (1) An employee who is absent from duty without prior approval shall report the reason for his absence to his supervisor immediately.

(2) Unauthorized or unreported absence shall:

(a) Be considered absence without leave;

(b) Be treated as leave without pay for an employee covered by the provisions of the Fair Labor Standards Act; and

(c) Constitute grounds for disciplinary action.

(3) An employee who has been absent without leave or notice to the supervisor for a period of ten (10) working days shall be considered to have resigned his employment.

Section 11. Absences Due to Adverse Weather. (1) An employee, who is not designated for mandatory operations and chooses not to report to work or chooses to leave early in the event of adverse weather conditions such as tornado, flood, blizzard, or ice storm, shall have the time of his absence reported as:

(a) Charged to annual or compensatory leave;

(b) Taken as leave without pay, if annual and compensatory leave has been exhausted; or

(c) Deferred in accordance with subsections (3) and (4) of this section.

(2) An employee who is on prearranged annual, compensatory, or sick leave shall charge leave as originally requested.

(3) If operational needs allow, except for an employee in mandatory operations, management shall make every reasonable effort to arrange schedules whereby an employee will be given an opportunity to make up time not worked rather than charging it to leave.

(4) An employee shall not make up work if the work would result in the employee working more than forty (40) hours in a workweek.

(a) Time lost shall be made up within four (4) months of the occurrence of the absence. If it is not made up within four (4) months, annual or compensatory leave shall be deducted to cover the absence, or leave without pay shall be charged if no annual or compensatory leave is available. (b) If an employee transfers or separates from employment before the leave is made up, the leave shall be charged to annual or compensatory leave or deducted from the final paycheck.

(5) If catastrophic, life-threatening weather conditions occur, as created by a tornado, flood, ice storm, or blizzard, and it becomes necessary for authorities to order evacuation or shutdown of the place of employment, the following provisions shall apply:

(a) An employee who is required to evacuate or who would report to a location that has been shut down shall not be required to make up the time that is lost from work during the period officially declared hazardous to life and safety; and

(b) An employee who is required to work in an emergency situation shall be compensated pursuant to the provisions of Section 5 of this administrative regulation and the Fair Labor Standards Act as amended.

Section 12. Blood Donation Leave. (1) An employee who, during regular working hours, donates blood at a licensed blood center certified by the Food and Drug Administration shall receive four (4) hours leave time, with pay, for the purpose of donating and recuperating from the donation.

(2) Leave granted under this section shall be used at the time of the donation unless circumstances as specified by the supervisor required the employee to return to work. If the employee returns to work, the unused portion of the leave time shall be credited as compensatory leave.

(3) An employee shall request leave in advance to qualify for blood donation leave. An employee who is deferred from donating blood shall not:

(a) Be charged leave time for the time spent in the attempted donation; and

(b) Qualify for the remainder of the blood donation leave.

Section 13. Incorporation by Reference. (1) "Overtime Compensation Form", May 2013[~~March 2011~~], is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Personnel Cabinet, 501 High Street, 3rd Floor, Frankfort Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

TIM LONGMEYER, Cabinet Secretary

APPROVED BY AGENCY: May 14, 2013

FILED WITH LRC: May15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Monday, June 24, 2013 at 11:00 a.m. at 501 High Street, 3rd Floor, Conference Room, 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 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 July 1, 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: Dinah T. Bevington, Executive Director, Office of Legal Services, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601, phone (502) 564-7430, fax (502) 564-0224.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Dinah T. Bevington

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation details the various types of unclassified leave available to state employees.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the various types of leave available for state unclassified employees, and the requirements for these types of leave.

(c) How this administrative regulation conforms to the content of the authorizing statutes: Pursuant to 18A.030(2), the Personnel Cabinet Secretary is required to promulgate comprehensive regulations consistent with the provisions for KRS Chapter 18A. KRS 18A.110(7)(g) requires the Secretary of Personnel, with the approval of the Governor, to promulgate administrative regulations which govern annual leave, sick leave, special leaves of absence, and other conditions of leave.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation assists in the consistent application and treatment for unclassified employees on all employment leave matters.

(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 amendments clarify that holiday pay does not count towards service time to qualify for the health and life insurance state contributions. Additionally, the amendments clarify the handling of sick leave without pay. The amendments also include the ability for employees to change the election of compensatory leave in lieu of overtime pay every three (3) months rather than every six (6) months. The amendments clarify that military leave shall be consistent with the time provided in KRS 61.373. Finally, the amendments remove the "with pay" language from the title of a provision where unpaid sick leave may be utilized in certain circumstances, consistent with the classified leave regulation.

(b) The necessity of the amendment to this administrative regulation: These amendments are necessary to ensure the consistent application and handling of sick leave without pay and military leave. These amendments are also necessary to document the process by which an employee's overtime election can be changed.

(c) How the amendment conforms to the content of the authorizing statutes: Pursuant to 18A.030(2), the Personnel Cabinet Secretary is required to promulgate comprehensive regulations consistent with the provisions for KRS Chapter 18A. KRS 18A.110(7)(g) requires the Secretary of Personnel, with the approval of the Governor, to promulgate administrative regulations which govern annual leave, sick leave, special leaves of absence, and other conditions of leave. These amendments clarify the processes and handling of employee leave, which is authorized pursuant to the statutes cited herein.

(d) How the amendment will assist in the effective administration of the statutes: These amendments are necessary to ensure the consistent application and handling of employee leave.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All KRS Chapter 18A unclassified employees and other individuals subject to the provisions of 101 KAR 3:015 will be affected.

(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: All actions which are required to comply with the amendments to the regulation have been taken by the Personnel Cabinet.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): No additional benefits will accrue that do not otherwise exist.

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

(a) Initially: This regulation, as amended, is not anticipated to generate any new or additional costs.

(b) On a continuing basis: This regulation, as amended, is not anticipated to generate any new or additional costs.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: This regulation, as amended, is not anticipated to generate any new or additional costs.

(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 regulation, as amended, is not anticipated to generate any new or additional fees or funding.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This regulation, as amended, is not anticipated to generate any new or additional fees.

(9) TIERING: Is tiering applied? No. All KRS Chapter 18A unclassified employees and other individuals subject to the provisions of 101 KAR 3:015 are treated the same.

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? All state agencies with employees covered under KRS Chapter 18A are impacted.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 18A.030(2) and KRS 18A.110(7)(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 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.

(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.

(c) How much will it cost to administer this program for the first year? There are no estimated additional costs to administer the amendments within this regulation.

(d) How much will it cost to administer this program for subsequent years? There are no estimated additional costs to administer the amendments within this 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:

PERSONNEL CABINET
Office of the Secretary
(Amendment)

101 KAR 3:050. Unclassified service; promotion, transfer and disciplinary actions.

RELATES TO: KRS 12.040, 12.050, 18A.115, 18A.155

STATUTORY AUTHORITY: KRS 18A.155(i)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 18A.155(1) requires the Secretary of Personnel to promulgate administrative regulations for persons in positions enumerated in KRS 18A.115(1)(g), (h), (i), (j), (k), (p), (t), and (u). KRS 18A.155(2) provides that administrative regulations promulgated pursuant to KRS 18A.155(1) may be used on behalf of employees enumerated in KRS 18A.115(1)(a), (b), (d), (e), (p), (u), and (w) and on behalf of members of state boards and commissions who work on a full-time, salaried basis. This administrative regulation establishes requirements for the employment, promotion, transfer or discipline of employees in unclassified service.

Section 1. Appointment. (1) An employee appointed to a position in the unclassified service, subject to this administrative regulation, shall meet the minimum requirements established for the class of position to which the appointment is made.

(2) An interim employee may serve in an interim capacity for less than nine (9) full months in a single department during a twelve (12) month period.

(3) An employee appointed to a position subject to this administrative regulation shall serve at the will of the appointing authority and shall be subject to termination without prior notice or cause.

Section 2. Promotion. (1) A vacant position subject to this administrative regulation, other than an interim position, may be filled by promotion from the classified or unclassified service.

(2) If the promotion is to a position requiring approval under KRS 12.040 or 12.050, approval shall be obtained prior to the effective date of the promotion.

Section 3. Transfer. (1) A vacant position subject to this administrative regulation, other than an interim position, may be filled by transfer within the[~~from the classified or~~] unclassified service.

(2) If the transfer is to a position requiring approval under KRS 12.040 or 12.050, approval shall be obtained prior to the effective date of the transfer.

Section 4. Demotion. (1) An employee subject to this administrative regulation, other than an interim employee, may be demoted to another position subject to this administrative regulation with or without cause on a voluntary or involuntary basis. An involuntary demotion shall be done on an intra-agency basis only.

(2) If the demotion is to a position requiring approval under KRS 12.040 or 12.050, approval shall be obtained prior to the effective date of the action.

Section 5. Detail to Special Duty. (1) If the services of an employee subject to this administrative regulation, other than an interim employee, are needed in an unclassified position within an agency other than the position to which regularly assigned, the employee may be detailed to that position for a period not to exceed one (1) year with approval of the Secretary of Personnel.

(2) If the detail is to a position requiring approval under KRS 12.040 or 12.050, approval shall be obtained prior to the effective date of the detail.

Section 6. Temporary Overlap. (1) With the prior approval of the Secretary of Personnel, an agency may place an employee, other than an interim employee, in an unclassified position currently occupied by another employee for a period not to exceed ninety (90)[~~sixty (60)~~] calendar days for training purposes.

(2) If the overlap is in a position requiring approval under KRS 12.040 or 12.050, approval shall be obtained prior to the effective date of the action.

Section 7. Separations. (1) Resignations and retirement.

(a) An employee who desires to terminate his service with the state shall submit a written resignation or notice of retirement to the appointing authority.

(b) A resignation or notice of retirement shall be submitted at least fourteen (14) calendar days before the final working day. A copy of an employee's resignation or notice of retirement shall be attached to the personnel action effecting the separation and shall be filed in the employee's service record in the agency and the Personnel Cabinet.

(c) Failure of an employee to give fourteen (14) calendar days notice of resignation or notice of retirement may result in forfeiture of accrued annual leave.

(2) Termination. An employee subject to this administrative regulation may be terminated with or without cause.

(a) If the appointing authority elects to terminate the employee for cause, the employee shall be provided with notice in writing of the reasons for termination and of the employee's right to appeal to the Personnel Board under KRS 18A.095.

(b) If the appointing authority elects to terminate the employee without cause, this decision shall be stated in the written notice to the employee.

Section 8. Applicability for Classified Employees. Except as provided in this administrative regulation, the provisions of 101 KAR 2:095, 101 KAR 2:105, 101 KAR 2:140, 101 KAR 2:150 and 101 KAR 2:160 shall apply to an employee in the unclassified service.

TIM LONGMEYER, Cabinet Secretary

APPROVED BY AGENCY: May 14, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Monday, June 24 at 11:30 a.m. at 501 High Street, 3rd Floor, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing within 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. 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 July 1, 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: Dinah T. Bevington, Office of Legal Services, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601, phone (502) 564-7430, fax (502) 564-0224.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Dinah T. Bevington

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes requirements for the employment, promotion, transfer or discipline of employees in unclassified service.

(b) The necessity of this administrative regulation: This regulation is necessary for the effective and proper application of requirements for employees in the unclassified service.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 18A.030 allows the Secretary of Personnel to promulgate comprehensive administrative regulations consistent with the provisions of KRS Chapters 13A and 18A.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation establishes requirements for the employment, promotion, transfer or discipline of employees in unclassified service. This regulation assists in the effective administration of the unclassified service.

(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 regulation, as amended, changes the period of temporary overlap from sixty (60) days to ninety (90) days. Additionally, the amendments will clarify that prior notice is not necessary for the termination of an unclassified employee, but an unclassified employee is entitled to notice of termination. Finally, the amendments clarify that transfers to the unclassified service but be made from employees within the unclassified service.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to promote efficiency in the unclassified service. The change from 60 days to 90 days is necessary because this is the mechanism to allow an employee to perform the duties of another employee who may be off on medical or military leave, and this is consistent with the amendments within the classified regulation. Additional clarification is necessary pertaining to the notice required for unclassified employees and the handling of transfer actions within the unclassified service.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment complies with KRS 18A.030(2), 18A110(1)(c)(d)(g) and (7).

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide relief to state agencies by ensuring work is performed in the absence of key personnel.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All KRS Chapter 18A unclassified employees and those employees subject to 101 KAR 3:050.

(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 actions are required to comply with the amendment.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Since there are no actions required to comply with the amendment, there are no additional costs anticipated to each of the entities identified.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This change will provide flexibility to agencies to ensure the continued operation of services. A temporary overlap can be used for training purposes such as when an employee is separating from state service and another employee has been selected for the position. A temporary overlap can also be used to place an employee in a position that is currently occupied but the incumbent employee is excused from work by medical or military leave. A temporary overlap has to be approved by the Secretary of the Personnel Cabinet and consecutive overlaps are discouraged. The extra time will assist agencies and eliminate administrative paperwork. Executive Branch agencies will not have to use the ninety (90) days, but this provides relief for long term situations.

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

(a) Initially: It is not anticipated that this regulation, as amended, will result in additional costs.

(b) On a continuing basis: It is not anticipated that this regulation, as amended, will result in additional costs.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: It is not anticipated that this regulation, as amended, will result in additional costs.

(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 regulation, as amended, is not anticipated to require additional funding for agencies governed by KRS Chapter 18A.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This regulation, as amended, is not anticipated to generate any new or

additional fees.

(9) TIERING: Is tiering applied? No. All unclassified employees are treated the same.

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? All state agencies with employees covered under KRS Chapter 18A.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 18A.030 (2), 18A.110 (1)(c), (d), (g) and (7).

(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.

(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.

(c) How much will it cost to administer this program for the first year? It is not anticipated that this regulation, as amended, will result in additional costs.

(d) How much will it cost to administer this program for subsequent years? It is not anticipated that this regulation, as amended, will result in additional costs.

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 Pharmacy
(Amendment)

201 KAR 2:020. Examination.

RELATES TO: KRS 218A.205(7)[~~(3)(g)~~], 315.050

STATUTORY AUTHORITY: KRS 218A.205(7)[~~(3)(g)~~], 315.050(2), 315.191(1), (2), (4)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 315.050(2) and 315.191(1)(c) authorize the board to promulgate administrative regulations to prescribe the time, place, method, manner, scope, and subjects of examinations. KRS 218A.205(7)[~~(3)(g)~~] requires the board to establish requirements for background checks for licensees. This administrative regulation establishes the examination and application requirements for obtaining a license to practice pharmacy in Kentucky.

Section 1. The examination for licensure shall include:

(1) The North American Pharmacist Licensure Examination (NAPLEX); and

(2) The Multistate Pharmacy Jurisprudence Examination (MPJE).

Section 2. The passing score on the required examinations shall be:

(1) At least seventy-five (75) on the basis of the NAPLEX and the MPJE grades shall not be used in computing the NAPLEX; and

(2) At least seventy-five (75) on the basis of the MPJE.

Section 3. If an applicant fails to obtain the necessary scores in any of the tests described in Section 2 of this administrative regulation, the applicant may upon proper application retake the tests upon the payment of the fee set forth in 201 KAR 2:050 plus any direct costs for test materials and supplies. An applicant who has failed any test may retake that test within one (1) year of the date the applicant first failed the test without having to reapply.

Section 4. All results of examinations shall be preserved according to the Board of Pharmacy Record Retention Schedule.

Section 5. Fees submitted with an application shall be nonrefundable.

Section 6. Prior to approval for examination, an applicant shall:

(1) Submit to a nation-wide criminal background investigation by means of fingerprint check by the Department of Kentucky State Police and[~~or~~] the Federal Bureau of Investigation; and

(2) Submit to a query to the National Practitioner Data Bank of the United States Department of Health and Human Services.

Section 7. License, Fee. An applicant shall submit:

(1) An Initial Application for Pharmacist Licensure pursuant to KRS 315.050; and

(2) As appropriate, the fee established by 201 KAR 2:050, Section 1(1).

Section 8. Incorporation by Reference. (1) "Initial Application for Pharmacist Licensure", Form 1, 7/2012, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Pharmacy, State Office Building Annex, Suite 300, 125 Holmes Street, Frankfort, Kentucky 40601, Monday through Friday 8:00 a.m. to 4:30p.m.

JOEL THORNBURY, President

APPROVED BY AGENCY: May 8, 2013

FILED WITH LRC: May 13, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Thursday June 27, 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 Monday, July 1, 2013 at 4:30 p.m. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT: 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 time, place, method, manner, scope and subjects of examination and establishes the examination requirements for obtaining a license to practice pharmacy in Kentucky.

(b) The necessity of this administrative regulation: This regulation is necessary to notify individuals of the examination requirements to obtain a license to practice pharmacy.

(c) How this administrative regulation conforms to the content of the authorizing statues: The regulation is in conformity with the authorizing statute that authorizes the board to promulgate administrative regulations regarding examinations to obtain a license to practice pharmacy.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation delineates the procedures for the requirements for examinations.

(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 will require an applicant to submit to a nation-wide criminal background investigation by means of fingerprint check by the Department of Kentucky State Police and the Federal Bureau of Investigation.

(b) The necessity of the amendment to this administrative regulation: Requires applicants that seek to obtain a license to practice pharmacy in Kentucky to submit to a nation-wide criminal background investigation by means of fingerprint check by the Department of Kentucky State Police and the Federal Bureau of Investigation.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment authorizes the board to promulgate regulations regarding the requirements for examination to obtain a license to practice pharmacy in Kentucky.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will allow the Board to require that individuals that apply for a license to practice pharmacy in Kentucky submit to a nation-wide criminal background investigation by the Department of the Kentucky State Police and the Federal Bureau of Investigation.

(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 around 350 individuals each year that apply for a license to practice pharmacy in Kentucky and will affect the Kentucky Board of Pharmacy and the Department of the Kentucky State Police.

(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: The Department of the Kentucky State Police will conduct a criminal background investigation on each applicant

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Each applicant will pay a fee to the Department of the Kentucky State Police and the Federal Bureau of Investigation for the criminal background investigation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): An applicant upon successful passing of both criminal background investigations will be allowed to sit for examinations to obtain a license to practice pharmacy in Kentucky.

(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: None

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation? None

(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 will be no new fee.

(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 regulation is applicable to any individual applying for a license to practice pharmacy in Kentucky.

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 the Kentucky State Police 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 218A.205(7), 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? Undetermined amount for the Department of the Kentucky State Police.

(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? Undetermined amount for the Department of the Kentucky State Police.

(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 Pharmacy
(Amendment)

201 KAR 2:030. License Transfer.

RELATES TO: KRS 315.210

STATUTORY AUTHORITY: KRS 218A.205(7)[~~(3)(g)~~], 315.191(1)(a)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 315.210 requires the board to establish conditions for licensure by reciprocity. KRS 218A.205(7)[~~(3)(g)~~] requires the board to establish requirements for background checks for licensees. This administrative regulation establishes conditions, forms, and examination requirements for licensure by reciprocity.

Section 1. Definitions. (1) "Board" is defined by KRS 315.010(3).

(2) "License transfer" means a license to practice pharmacy in Kentucky issued by the board to a pharmacist licensed in another jurisdiction.

(3) "NABP" means the National Association of Boards of Pharmacy.

Section 2. An applicant licensed in another jurisdiction shall be eligible for license transfer, if the:

(1) Requirements for licensure of the jurisdiction that granted his or her license met or exceeded Kentucky requirements for licensure at the time the license in the other jurisdiction was granted;

(2) Applicant has held in good standing, an active license to practice pharmacy during the entire year preceding the time of filing an application;

(3) Applicant has:

(a) Completed and certified the NABP Preliminary Application for Transfer of Pharmacist License form; and

(b) Received an[~~a~~] NABP Official Application for Transfer of Pharmacist License;

(4) Applicant is currently in good standing in the jurisdiction from which he or she has applied;

(5) Applicant has successfully completed an examination in jurisprudence;

(6) Applicant has submitted to a nation-wide criminal background investigation by means of fingerprint check by the Department of Kentucky State Police and[~~or~~] the Federal Bureau of Inves-

tigation; and

(7) Applicant has submitted to a query to the National Practitioner Data Bank of the United States Department of Health and Human Services.

Section 3. Required Information. An applicant shall provide the information required by the NABP Preliminary Application for Transfer of Pharmacist License form, including:

(1) Name, maiden, and other names used currently or previously;

(2) Address, telephone number;

(3) Date and place of birth, and current age;

(4) Social Security number;

(5) Citizenship;

(6) Gender;

(7) State of original license by examination, including:

(a) License number;

(b) Original date of issue;

(c) Current status of original licensure; and

(d) State for which license transfer is requested;

(8) Pharmacy education, including:

(a) Name and location of pharmacy school;

(b) Name of pharmacy degree;

(c) Date degree was received;

(d) Other professional degrees, including the information specified by paragraphs (a) to (c) of this subsection;

(9) Whether the applicant has earned certification by the Foreign Pharmacy Graduate Examination Committee, and, if so, the examination equivalency number assigned;

(10) Total hours of practical experience prior to licensure as a pharmacist, including the State Board of Pharmacy with which the hours are filed;

(11) States, dates, and results of pharmacist licensure examinations;

(12) Pharmacist licenses obtained by:

(a) Score transfer; and

(b) Licensure transfer;

(13) Practice and employment, including nonpharmacist employment, from initial licensure to the date of filing the application; and

(14) Record of charges, convictions, and fines imposed, or certification that the applicant has not been convicted, fined, disciplined, or had a license revoked.

Section 4. The board shall accept a license transfer from a jurisdiction that:

(1) Is an active member of the NABP; and

(2) Grants license transfer to a pharmacist pursuant to conditions and requirements that are the equivalent of conditions and requirements established by the board.

Section 5. An applicant shall take and pass the Multistate Pharmacy Jurisprudence Examination administered by the NABP.

Section 6. Fee. An applicant shall include the fee specified by 201 KAR 2:050, Section 1(2), (20).

Section 7. (1) "NABP Preliminary Application for Transfer of Pharmacist License", 3/06, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law at the Kentucky Board of Pharmacy, State Office Building Annex, Suite 300, 125 Holmes Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

JOEL THORNBURY, President

APPROVED BY AGENCY: May 8, 2013

FILED WITH LRC: May 13, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Thursday June 27, 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 Monday July 1, 2013 at 4:30 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 time, place, method, manner, scope and subjects of examination and establishes the examination requirements for obtaining a license to practice pharmacy in Kentucky.

(b) The necessity of this administrative regulation: This regulation is necessary to notify individuals of the examination requirements to obtain a license to practice pharmacy.

(c) How this administrative regulation conforms to the content of the authorizing statues: The regulation is in conformity with the authorizing statute that authorizes the board to promulgate administrative regulations regarding examinations to obtain a license to practice pharmacy.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation delineates the procedures for the requirements for examinations.

(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 will require an applicant to submit to a nation-wide criminal background investigation by means of fingerprint check by the Department of Kentucky State Police and the Federal Bureau of Investigation.

(b) The necessity of the amendment to this administrative regulation: Requires applicants that seek to obtain a license to practice pharmacy in Kentucky to submit to a nation-wide criminal background investigation by means of fingerprint check by the Department of Kentucky State Police and the Federal Bureau of Investigation.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment authorizes the board to promulgate regulations regarding the requirements for examination to obtain a license to practice pharmacy in Kentucky.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will allow the Board to require that individuals that apply for a license to practice pharmacy in Kentucky submit to a nation-wide criminal background investigation by means of fingerprint check by the Department of the Kentucky State Police and the Federal Bureau of Investigation.

(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 around 400 individuals each year that apply for a license to practice pharmacy in Kentucky and will affect the Kentucky Board of Pharmacy and the Department of the Kentucky State Police.

(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: The Department of the Kentucky State Police will conduct a criminal background investigation on each applicant.

(b) In complying with this administrative regulation or amend-

ment, how much will it cost each of the entities identified in question (3): Each applicant will pay a fee to the Department of the Kentucky State Police for a criminal background investigation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): An applicant upon successful passing of the nation-wide criminal background investigations will be allowed to sit for examinations to obtain a license to practice pharmacy in Kentucky.

(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: None

(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: No new fee will be accessed.

(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 regulation is applicable to any individual applying for a license to practice pharmacy in Kentucky.

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 and the Department of the Kentucky State Police 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 218A.205(7), 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? Undetermined amount for the Department of the Kentucky State Police.

(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? Undetermined amount for the Department of the Kentucky State Police.

(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
Kentucky State Board of Licensure for Professional Engineers and Land Surveyors
(Amendment)

201 KAR 18:040. Fees.

RELATES TO: KRS 322.060, 322.090, 322.100, 322.110, 322.120, 322.160, 322.170

STATUTORY AUTHORITY: KRS 322.090, 322.100, 322.110, 322.120, 322.290(4), 322.290(10)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322.100 requires the board to establish fees for licensure. This administrative regulation establishes fees for examination, licensure, reinstatement, reissuance, and renewal.

Section 1. Examination Fees.[~~(1)~~] The fees for taking the Principles and Practice of Engineering Examination, the Principles and Practice of Land Surveying Examination, the Fundamentals of Engineering Examination, and the Fundamentals of Land Surveying Examination shall be the actual amounts charged by the National Council of Examiners for Engineering and Surveying.[~~(2) The board shall reimburse examination fees for qualifying individuals as established in this subsection. To qualify for reimbursement, an applicant shall:~~

~~(a)1. Successfully complete with a passing score, an examination listed in subsection (1) of this section;~~

~~2.a. Be an active member of the Armed Forces of the United States whose military official home of record was Kentucky on the date the examination was taken; or~~

~~b. Be a veteran of the Armed Forces of the United States whose residence for income tax purposes was Kentucky on the date the examination was taken; and~~

~~3. Apply for reimbursement in writing to the board within one (1) year following the date the examination was taken, and include proof of:~~

~~a. Passing the examination;~~

~~b. Service in the Armed Forces of the United States; and~~

~~c. Kentucky being either the applicant's military official home of record or the applicant's residence for income tax purposes, on the date the examination was taken; or~~

~~(b)1. Successfully complete with a passing score, the Fundamentals of Engineering Examination or the Fundamentals of Surveying Examination for a student currently enrolled in a Kentucky university or college on the date the examination was taken; and~~

~~2. Apply for reimbursement in writing to the board within one (1) year following the date the examination was taken, and include proof of:~~

~~a. Passing the examination; and~~

~~b. Enrollment in a Kentucky university or college on the date the examination was taken.~~]

Section 2. Endorsement, Renewal, Reinstatement, and Reissuance. (1) Renewal of an individual license shall be $150 or shall be twenty (20) dollars for retired or inactive status.

(a) Each licensee whose surname begins with the letters A through K shall renew in odd-numbered years.

(b) Each licensee whose surname begins with the letters L through Z shall renew in even-numbered years.

(2) (a) The fee for reinstatement of an expired license or business entity permit that has been expired for less than one (1) year shall be calculated as provided by KRS 322.160(3).

(b) If the license or business entity permit has been expired for more than one (1) year, the former licensee or business entity shall file an application for reinstatement and pay a fee of $500.

(3) Reissuance of a license after loss or destruction shall be twenty-five (25) dollars.

(4) The fee for licensure by endorsement as a professional engineer or professional land surveyor shall be $300. The fee shall accompany the application for licensure, which is incorporated by reference in 201 KAR 18:020.

(5) An applicant who fails the two (2) hour state specific examination on the first attempt shall be charged fifty (50) dollars for each subsequent attempt.

Section 3. Fees for Examination[~~and Licensure~~] in Additional Disciplines. (1) After initial licensure, a licensee may apply for examination in one (1) or more disciplines of engineering for which examinations are available[~~he has not been licensed~~].

(2) For each additional examination an applicant[~~discipline of engineering he~~] shall submit an:

(a) Updated application, which is incorporated by reference in 201 KAR 18:020; and

(b) Examination fee as established in this administrative regulation.

Section 4. Business Entities. (1) The fee for a permit to practice engineering or land surveying in this state shall be $100 for either permit.

(2) A business entity that applies for a dual permit shall submit $150.

(3) These fees shall accompany the application.

(4) The annual renewal fee for an individual permit shall be $100.

(5) The annual renewal fee for a dual permit shall be $150.

Section 5. Payment of Fees. (1) (a) Fees payable pursuant to Sections 2 and 4 of this administrative regulation shall be paid by check or money order made payable to "Kentucky Board of Licensure" or by major credit card.

(b) Fees payable pursuant to Section 1 of this administrative regulation shall be paid directly to the examination service.

(2) All fees shall be nonrefundable.

B. DAVID COX, Executive Director

APPROVED BY AGENCY: May 3, 2013

FILED WITH LRC: May 6, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on June 21, 2013 at 1:30 p.m., local time, at 160 Democrat Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing of their intent to attend no later than five workdays prior to the date of the hearing. If no written notification of an individual's intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. If the public hearing is held, 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, in which case the person requesting the transcript shall have the responsibility of paying for same. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. 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 July 1, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Jonathan Buckley, General Counsel, Kentucky State Board of Licensure for Professional Engineers and Land Surveyors, 160 Democrat Drive, Frankfort, Kentucky 40601, phone (502) 573-2680, fax (502) 573-6687.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Jonathan Buckley

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation establishes fees for examination, licensure, reinstatement, verification, reissuance, and renewal.

(b) The necessity of this administrative regulation: KRS 322.100 requires the board to establish license fees.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation contains all fee amounts.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation sets all fees so that the board can charge the appropriate amount for each 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: This amendment deletes the provision for the reimbursement of exam fees. Additionally, this amendment clarifies requirements for payment of fees charged for applications for examinations in additional disciplines of engineering.

(b) The necessity of the amendment to this administrative regulation: Current budgetary considerations necessitate the board to restrict expenditures and the provision for reimbursement of exam fees was not required by statute, and represents an expenditure that in this economic reality is one this agency cannot afford. This amendment also corrects language to reflect that while exams are available for various disciplines of engineering, this board does not license engineers by specific discipline.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to KRS 322.100 since that statute gives the board the authority to set license fees.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide clarity to the issues of fees for examinations, and by elimination of a substantial non-statutory financial obligation, assist the board in maintaining sufficient funds to meet its statutory obligations.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: The elimination of the reimbursement obligation could, in any given year, potentially affect approximately ten present or former members of the Armed Services of the United States, and approximately 300 students, as well as the board itself in making reimbursements to those individuals.

(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) A detailed explanation of 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 additional actions will be required of either the licensees or the board.

(b) An estimate of the costs imposed on entities identified in question (3) in complying with this administrative regulation or amendment: There is no additional cost associated with this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This amendment will result in clarity of application of the regulation and by eliminating an expenditure, allow the board to apply its funds to meet the basic obligations mandated by statute.

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

a. Initially: $0

b. On a continuing basis: $0

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Restricted Agency Funds. The board receives no general or federal 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 funding will be necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: No fees are established or increased as a result of this regulation.

(9) TIERING: Is tiering applied? Tiering was not used because this regulation should not disproportionately affect any particular group of people.

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 State Board of Licensure for Professional Engineers and Land Surveyors.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 322.090, KRS 322.100, KRS 322.110, KRS 322.120, KRS 322.290(4), and KRS 322.290(10)

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. There will be no additional revenue or expenditure to any agency as a result of this amendment.

(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? There will be no additional cost involved in administering this program for the first year.

(d) How much will it cost to administer this program for subsequent years? There will be no additional cost involved in administering this program for the 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: There is no additional cost or revenue generated by this amendment.

GENERAL GOVERNMENT
Kentucky State Board of Licensure for Professional Engineers and Land Surveyors
(Amendment)

201 KAR 18:072. Experience.

RELATES TO: KRS 322.040, 322.045, 322.047

STATUTORY AUTHORITY: KRS 322.010, 322.040, 322.045(3), 322.047(2), 322.290(4)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322.040(4), 322.045(3), and 322.047(2) provides that the board shall promulgate administrative regulations to establish requirements for experience as required by KRS 322.040(1)(a)2. This administrative regulation establishes these requirements.

Section 1. Evaluation of experience in engineering required under KRS 322.040 shall consider the following:

(1) Experience shall reflect increasing complexity of the engineering tasks and the progressive responsibility of the applicant.

(2) The applicant shall demonstrate knowledge of engineering mathematics, physical and applied sciences, properties of materials, the fundamental principles of engineering design and the application of engineering principles in the solution of engineering problems.

(3) One (1) year of credit may be approved for completion of a master's degree in engineering in an EAC/ABET-accredited program, or one deemed equivalent by the board.

(4) Experience that violates KRS Chapter 322 shall not be approved.

(5) Engineering experience gained in the military services may be approved.

(6) Sales experience may be approved if engineering principles were required and used in that experience.

(7) Experience gained in teaching advanced-level engineering-related courses in a four (4) year EAC/ABET-accredited program, or one (1) deemed equivalent by the board, may be approved.

(8) Experience gained in engineering research and design projects by faculty in an EAC/ABET-accredited program, or one deemed equivalent by the board, may be approved.

(9) Experience may be approved for execution or supervision of construction projects designed by a professional engineer.

(10) The applicant shall demonstrate why experience not gained under the supervision of a professional engineer is eligible for credit.

(11) Qualifying experience shall be complete at the time of application for licensure.

(12) Qualifying experience required by KRS 322.040(1)(a)2 shall be gained following graduation from the engineering program required by the provisions of KRS 322.040(1)(a)1 <u>except that up to three (3) months of experience may be granted for qualifying experience earned while on active duty in the armed forces prior to graduating from the engineering program required by the provisions of KRS 322.040(1)(a)1</u>.

Section 2. Evaluation of experience in land surveying required under KRS 322.045 and 322.047 shall consider the following:

(1) Land surveying experience shall reflect increasing complexity of the land surveying tasks and the progressive responsibility of the applicant.

(2) Experience shall include projects in which the applicant, while under the direct supervision of a practicing professional land surveyor, implemented work involving property conveyance and property boundary determination. The applicant shall also demonstrate experience in the fieldwork aspects of property boundary determination.

(3) One (1) year of experience may be approved for completion of a master's degree in land surveying from a board-approved program in land surveying from a college or university.

(4) A maximum of two (2) years of experience shall be approved for land surveying work prior to graduation under KRS 322.045(1)(c)1, 2, 3, and 322.047(1)(a)1 and 2.

(5) Experience that violates KRS Chapter 322 shall not be approved.

(6) Land surveying experience gained in the military services may be approved.

(7) A maximum of two (2) years of experience may be approved for teaching land surveying courses at the postsecondary level.

(8) Qualifying experience shall be complete at the time of application.

(9) Notwithstanding subsections (3), (4), and (7), in no case shall an applicant's experience gained after graduation be less than two (2) years.

B. DAVID COX, Executive Director

APPROVED BY AGENCY: May 3, 2013

FILED WITH LRC: May 6, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on June 21, 2013 at 2:30 p.m., local time, at 160 Democrat Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing of their intent to attend no later than five workdays prior to the date of the hearing. If no written notification of an individual's intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. If the public hearing is held, 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, in which case the person requesting the transcript shall have the responsibility of paying for same. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. 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 July 1, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Jonathan Buckley, General Counsel, Kentucky State Board of Licensure for Professional Engineers and Land Surveyors, 160 Democrat Drive, Frankfort, Kentucky 40601, phone (502) 573-2680, fax (502) 573-6687.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Jonathan Buckley

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation establishes the requirements for the experience component of engineering and surveying licensure.

(b) The necessity of this administrative regulation: KRS 322.040(4) and 322.045(3) requires the board to establish an administrative regulation for experience.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 322.290(4) authorizes the board to promulgate administrative regulations necessary for the proper performance of its duties. The regulation establishes experience

requirements per KRS 322.040(4) and 322.045(3).

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation establishes detailed requirements related to the experience component of engineering and surveying licensure to assist the board in evaluating applicants for licensure.

(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 proposed amendment addresses the requirement set out in KRS 322.040(4) regarding the consideration of engineering experience gained prior to graduation from the engineering program described in subsection (1)(a.)1 of this regulation, by identifying such qualifying experience.

(b) The necessity of the amendment to this administrative regulation: The proposed amendment is necessary to clarify what pre-graduation experience will be considered.

(c) How the amendment conforms to the content of the authorizing statutes: The proposed amendment clarifies qualifying pre-graduation experience as required by KRS 322.040(4).

(d) How the amendment will assist in the effective administration of the statutes: The proposed amendment will provide the information necessary for the board to evaluate the experience component for engineering applicants.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This proposed regulation will not affect businesses, organizations, or state and local governments. It will affect only engineering applicants who attempt to use experience gained prior to graduation.

(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) A detailed explanation of 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 board will continue to administer the experience regulation. No additional actions will be required of either the licensees or the board.

(b) An estimate of the costs imposed on entities identified in question (3) in complying with this administrative regulation or amendment: There is no additional cost associated with this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This amendment will allow establish the type of pre-graduation experience and the maximum amount of such credit that may be given for such experience, that the board will consider in satisfaction of the experience requirement for engineering licensure.

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

a. Initially: $0

b. On a continuing basis: $0

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Restricted Agency Funds. The board receives no general or federal 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 funding will be necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: No fees are established or increased as a result of this regulation.

(9) TIERING: Is tiering applied? Tiering was not used because this regulation should not disproportionately affect any particular group of people.

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 State Board of Licensure for Professional Engineers and Land Surveyors

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 322.040(4)

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. There are no revenue or expenditure effects for any government agency.

(a) How much revenue will this administrative regulation generate for the state or local government agency (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 agency (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? $0

(d) How much will it cost to administer this program for subsequent years? $0

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: There is no additional cost or revenue generated by this amendment.

GENERAL GOVERNMENT
Kentucky State Board of Licensure for Professional Engineers and Land Surveyors
(Amendment)

201 KAR 18:142. Code of professional practice and conduct.

RELATES TO: KRS 322.180(3), 322.290(11)

STATUTORY AUTHORITY: KRS 322.290(11)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322.290(11) requires the board to promulgate a code of professional practice and conduct, which shall be binding upon persons licensed under KRS Chapter 322. This administrative regulation establishes a code of professional practice and conduct.

Section 1. Definitions. (1) "Conflict of interest" means any circumstance in which a licensee's personal or financial interest is contrary to the interests of the public, his or her employer, or current or past client.

(2) "Direct supervisory control" in the practice of engineering means that an engineer licensee directly supervises and takes responsibility for consultation, investigation, evaluation, planning, design and certification of an engineering project and includes only that work performed by an employee as defined in subsection (4) of this section.(3) "Direct supervisory control" in the practice of land surveying means that a surveyor licensee who certifies a work product directly supervises and takes responsibility for the survey and includes only that work performed by an employee as defined in subsection (4) of this section.

(4) "Employee" means a person who works for a licensee or his or her employer for wages or a salary and includes professional and technical support personnel contracted on a temporary or occasional basis, if the compensation is paid directly by the licensee or his or her employer. It does not include a person who provides services to the licensee as an outside consultant or specialist.

(5) "Licensee" means any natural person licensed by the board to practice professional engineering or professional land surveying, or any business entity permitted under KRS 322.060.

(6) "Work product" means any engineering or land surveying plan, plat, document or other deliverable requiring certification that is intended to represent activities conducted in the practice of en-

gineering or land surveying.

Section 2. The engineer or land surveyor shall conduct his or her practice in order to protect the public health, safety, and welfare.

(1) The practice of professional engineering and land surveying is a privilege, and not a right.

(2) If a licensee's judgment is overruled and a licensee has reason to believe the public health, safety or welfare may be endangered, the licensee shall inform his or her employer or client of the possible consequences and, if not resolved, notify appropriate authorities.

Section 3. A licensee shall issue all professional communications and work products in an objective and truthful manner.

(1) A licensee shall be objective and truthful in all professional reports, statements or testimony and shall include all material facts.

(2) If serving as an expert or technical witness before any tribunal, a licensee shall express an opinion only if it is founded on adequate knowledge of the facts in issue, on the basis of technical competence in the subject matter, and upon honest conviction of the accuracy and propriety of that testimony, and shall act with objectivity and impartiality. A licensee shall not ignore or suppress a material fact.

(3) A licensee shall not issue a statement or opinion on professional matters connected with public policy unless the licensee has identified himself or herself, has disclosed the identity of the party on whose behalf the licensee is speaking, and has disclosed any pecuniary interest the licensee may have in the matter.

(4) A licensee shall not maliciously injure the professional reputation, prospect, practice or employment of another licensee.

(5) A licensee shall not accept a contingency fee for serving as an expert witness before any tribunal.

(6) A licensee shall maintain for a period of not less than five (5) years, calculations and documents necessary to support work products.

(7) A professional land surveyor shall maintain records for boundary surveys under 201 KAR 18:150, Section 10(2) and (3).

(8) The requirements of subsections (6) and (7) of this section shall be satisfied for the individual licensee employed by a business entity permitted by the board in conformance with KRS 322.060 by that permitted entity's compliance with subsections (6) and (7) of this section.

Section 4. A licensee shall avoid conflicts of interest. (1) If a reasonable possibility of a conflict of interest exists, a licensee shall promptly notify his or her employer, client or past client.

(2) A licensee shall not accept a valuable consideration from more than one (1) party for services pertaining to the same identical project, unless the circumstances are fully disclosed to all other principal parties directly involved in the project.

(3) A licensee shall not solicit or accept a valuable consideration either for specifying materials or equipment, or from contractors, their agents or other parties dealing with a client or employer in connection with work for which the licensee is responsible.

(4) A licensee shall not solicit or submit proposals for professional services containing a false, fraudulent, misleading, deceptive or unfair statement regarding the cost, quality or extent of services to be performed.

(5) A licensee shall not misrepresent his or her professional qualifications or experience, or those of the licensee's associates.

(6) A licensee serving as a member, advisor, or employee of a governmental body shall not participate in decisions with respect to professional services offered or provided by him or her or by a business entity in which the licensee is a principal, officer or employee, to that governmental body.

Section 5. A licensee shall solicit or accept engineering or land surveying work only on the basis of his or her, or the licensee's firm's or associates' qualifications for the work offered.

(1) A licensee shall not offer or accept any valuable consideration in order to secure specific work, exclusive of commissions paid by individual licensees for securing salaried positions through employment agencies. A licensee may participate in design-build projects.

(2) A licensee may advertise professional services if the advertising is not false or misleading.

Section 6. A licensee shall not knowingly associate with any person engaging in fraudulent, illegal or dishonest activities. (1) A licensee shall not permit the use of his or her, or the licensee's business entity's name by any person or business entity that he or she knows or has reason to believe is engaging in fraudulent, dishonest or illegal activities.

(2) A licensee shall not aid or abet the illegal practice of engineering or land surveying.

Section 7. A licensee shall perform his or her services only in the areas of his or her competence.

(1) A licensee shall undertake to perform professional assignments only if qualified by education or experience in the specific technical field involved.

(2) A licensee may accept an assignment requiring education or experience outside his or her own field of competence, but only to the extent that his or her services are restricted to those parts of the project in which the licensee is competent. All other parts of the project shall be certified by licensed associates, consultants or employees.

(3) If a question of the competence of a licensee to perform a professional assignment in a specific technical field is an issue and cannot be otherwise resolved to the satisfaction of the board, the board, upon a majority vote or upon request by the licensee, may require the licensee to satisfactorily complete an examination the board deems appropriate and relevant.

Section 8. Except as provided by this section, a licensee shall not certify any work product dealing with subject matter in which he or she lacks competence by virtue of education or experience, or any work product not prepared by him or her under his or her direct supervisory control.

(1) A professional engineer may review and certify the work product of another professional engineer if:

(a) The review and certification are made at the request of the other professional engineer;

(b) He or she does not remove or obliterate the identity of the other professional engineer;

(c) He or she performs and retains in his or her possession for not less than five (5) years all calculations and documents necessary to perform an adequate review; and

(d) He or she confirms that the other professional engineer was licensed when the work was created.

(2) If a professional engineer undertakes to review only a portion of the work product of another professional engineer, his or her certification shall clearly identify the portion reviewed.

(3) A professional engineer may modify the work product of another professional engineer, whether or not the project has been built, if he or she retains in his or her possession for not less than five (5) years a record of his or her modifications.

(4) If a professional engineer modifies the work product of another professional engineer, his or her certification shall clearly identify, by words or graphics, that portion that was modified.

(5) A professional engineer may incorporate in his or her work product the designs of manufactured or standard components developed by manufacturers, suppliers or professional or technical societies and associations.

(6) If, in the professional land surveyor's reasonable judgment, his or her personal participation is not required in performing a particular aspect of a project, he or she may delegate those tasks to an employee, if all work is actually reviewed by the licensee.

(7) The need for a professional land surveyor to make a site visit shall be dictated by the nature, size and complexity of a project. However, the failure to make a site visit in a substantial percentage of surveys may be construed as a failure to exercise direct supervisory control.

(8) While an employee may investigate the circumstances of a potential project, only a licensee may establish the scope of work to be performed.

Section 9. The professional engineer or professional land surveyor shall avoid conduct likely to discredit or reflect unfavorably upon the dignity or honor of his or her profession.

Section 10. If a licensee has knowledge or reason to believe that any person or other licensee is in violation of KRS Chapter 322 or any administrative regulation adopted by this board, the licensee shall present that information to the board in writing and shall cooperate with the board in furnishing information within his or her knowledge.

Section 11. A licensee shall not, directly or indirectly, contact a board member concerning any ongoing disciplinary action, or any existing investigation being conducted by the board staff. Any and all communications by any licensee concerning such disciplinary action or investigation shall be made only to board staff.

B. DAVID COX, Executive Director

APPROVED BY AGENCY: May 3, 2013

FILED WITH LRC: May 6, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on June 21, 2013 at 2:00 p.m., local time, at 160 Democrat Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing of their intent to attend no later than five workdays prior to the date of the hearing. If no written notification of an individual's intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. If the public hearing is held, 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, in which case the person requesting the transcript shall have the responsibility of paying for same. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. 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 July 1, 2013. Send written notification of intent to be heard at the public hearing or written comments on the proposed notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Jonathan Buckley, General Counsel, Kentucky State Board of Licensure for Professional Engineers and Land Surveyors, 160 Democrat Drive, Frankfort, Kentucky 40601, phone (502) 573-2680, fax (502) 573-6687.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Jonathan Buckley

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation establishes a code of professional practice and conduct for professional engineers and land surveyors.

(b) The necessity of this administrative regulation: KRS 322.290(11) requires the board to adopt and promulgate by administrative regulation a code of professional practice and conduct, which shall be based upon generally recognized principles of professional ethical conduct and binding upon persons licensed under KRS Chapter 322.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The provisions of this regulation constitute the code required by KRS 322.290.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation establishes written requirements for professional practice and conduct so that licensees may understand what is required of them, and assists board staff to insure compliance with those provisions.

(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 adds a provision that specifically sets out the prohibition of a licensee contacting a board member with regard to any investigation or disciplinary action by board staff.

(b) The necessity of the amendment to this administrative regulation. While the behavior addressed by the amendment would be commonly understood to be prohibited and unethical, this additional language will remove any possible doubt that such behavior is impermissible.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the mandate of KRS 322.290(11) since this provision is directed at one aspect of licensees acting ethically.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide clarity to the issue of any licensee contacting a board member with regard to any disciplinary or investigative matter and will assist the board staff in enforcing compliance with ethical behavior by a licensee.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: It will affect all licensees, approximately 12,000 in number, though those same licensees should already be aware that it would unethical to contact a board member with regard to any investigative or disciplinary matter, since the board as a whole sits in ultimate judgment of those matters.

(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) A detailed explanation of 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 additional actions will be required of either the licensees or the board.

(b) An estimate of the costs imposed on entities identified in question (3) in complying with this administrative regulation or amendment: There is no additional cost associated with this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This amendment will assist any licensee in understanding that he or she should not be contacting a board member with regard to any investigative or disciplinary matter, and that he or she should instead, contact board staff.

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

(a) Initially: $0

(b) On a continuing basis: $0

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Restricted Agency Funds. The board receives no general or federal 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 funding will be necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: No fees are established or increased as a result of this regulation.

(9) TIERING: Is tiering applied? Tiering was not used because this regulation should not disproportionately affect any particular group of people.

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 State Board of Licensure for Professional Engineers and Land Surveyors.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 322.290(11)

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. There will be no additional revenue or expenditure to any agency as a result of this amendment.

(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 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? $0

(d) How much will it cost to administer this program for subsequent years? $0

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: There is no additional cost or revenue generated by this amendment.

GENERAL GOVERNMENT CABINET
Kentucky Board of Registration for Professional Geologists
(Amendment)

201 KAR 31:010. Fees.

RELATES TO: KRS 322A.050, 322A.060, 322A.070

STATUTORY AUTHORITY: KRS 322A.030(5), 322A.050, 322A.060(1), 322A.070(1), (3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322A.050 requires the board to establish the application and examination fees. KRS 322A.060 requires the board to establish renewal fees. KRS 322A.070 requires the board to establish the replacement fee. This administrative regulation sets forth the fees charged by the board to apply for registration or certification, sit for the examination, to renew and reinstate a registration.

Section 1. Application Fee. The application fee for registration as a professional geologist or certification as a geologist-in-training shall be $100 which shall be non-refundable and shall be paid with the filing of the application[~~fifty (50) dollars~~].

Section 2. Examination Fees. The following fees shall be paid with the filing of the application in connection with the licensure examinations required by the board:

(1) The fee for the Fundamentals of[~~in~~] Geology (FG) portion of the examination shall be $175 for each initial and subsequent administration[~~$125~~].

(2) The fee for the Practice of Geology (PG) portion of the examination shall be $225 for each initial and subsequent administration[~~$150~~].

Section 3. Initial Licensure Fee. (1) Upon passage of the examinations required in Section 2 of this administrative regulation, the initial licensure fee for registration as a professional geologist or certification as a geologist-in-training for each application filed from January 1 to September 30 of each odd numbered year shall be fifty (50) dollars.

(2) Upon passage of the examinations required in Section 2 of this administrative regulation, the initial licensure fee for registration as a professional geologist or certification as a geologist-in-training for each application filed from October 1 of each odd numbered year to December 31 of each even numbered year shall be $100.

Section 4. Biennial Renewal Fees and Penalties. The following fees shall be paid in connection with licensure and certification renewals and late renewal penalties:

(1) The biennial renewal fee for registration as a professional geologist or certification as a geologist-in-training shall be $100[~~fifty (50) dollars~~];

(2) The late biennial renewal fee as a professional geologist or certification as a geologist-in-training, including penalty, for late renewal during the ninety (90) day grace period shall be $150[~~seventy-five (75) dollars~~]; and

(3) The reinstatement fee for registration as a professional geologist or certification as a geologist-in-training renewal after the end of the ninety (90) day grace period shall be $200[~~$100~~].

Section 5[4]. Duplicate Registration or Certification Fees. The fee for a duplicate of the original registration or certification certificate shall be ten (10) dollars.

LARRY R. RHODES, Chairman

APPROVED BY AGENCY: April 1, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held June 28, 2013, at 1:00 p.m., at the Office of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify the agency in writing by 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 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. Written comments shall be accepted until July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Lindsey Lane, Board Administrator, Kentucky Board of Registration for Professional Geologists, Division of Occupations and Professions, 911 Leawood Drive, P. O. Box 1360, Frankfort, Kentucky 40601, phone (502) 564-3296, ext. 228, fax (502) 696-4961.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Brian Judy

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation sets forth the fees charged by the board to apply for registration or certification, sit for the examination, to renew and reinstate a registration.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish certain fees for licensure.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 322A.050 requires the board to establish the application and examination fees. KRS 322A.060 requires the board to establish renewal fees. KRS 322A.070 requires the board to establish the replacement fee.

(d) How this administrative regulation will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the statutes by informing applicants and licensees of the required fees.

(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: This amendment sets the fee for the examination at the current rate required by the examination provider. This amendment also sets the renewal fee to account for the biennial renewal process that the board is implementing.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to allow the board to change the renewal process from yearly renewal to biennial renewal.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the biennial renewal process established in the 2012 session of the General Assembly.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are approximately 1,500 individuals licensed by 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: Applicants for a license from the board will be required to pay the fees for the required examinations and for the initial license.

(b) In complying with this administrative regulation or amendment, how much will it cost for each of the entities: The renewal fees are not being increased, as the renewal fee now covers a two year period rather than a yearly fee. The fee for the application, examination and initial licensure will be six hundred (600) dollars.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3):
Applicants will be granted a license upon complying with the requirements. Licensees will be able to maintain their license to practice geology in the Commonwealth.

(5) Estimate of how much it will cost to implement this administrative regulation:

(a) Initially: None.

(b) On a continuing basis: None.

(6) The source of funding for the implementation and enforcement of this administrative regulation: The board is funded solely from fees paid by applicants and licensees.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation: This administrative regulation establishes the fees necessary to operate the board.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees. This administrative regulation establishes the fees required for receiving a license from the Board and for renewing a license.

(9) TIERING: Is tiering applied? Tiering was not applied. The fees are required of any person licensed by the board.

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? Board of Registration for Professional Geologists.

2. Identify each state or federal statute or federal regulation that authorizes the action taken by the administrative regulation: KRS 322A.030(5), 322A.050, 322A.060(1), 322A.070(1), (3).

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

(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? N/A.

(c) How much will it cost to administer this program for the first year?

(d) How much will it 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:

GENERAL GOVERNMENT CABINET
Kentucky Board of Registration for Professional Geologists
(Amendment)

201 KAR 31:020. Compensation of board members.

RELATES TO: KRS 322A.020(7)

STATUTORY AUTHORITY: KRS 322A.020(7), 322A.030

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322A.020(7) requires the board to set the compensation for board members by administrative regulation. This administrative regulation sets the compensation of board members.

Section 1. Eligible members of the board shall receive compensation in the amount of $150[~~$100~~] per day for each day of actual board service and travel expenses to the extent authorized by 200 KAR Chapter 2.

LARRY R. RHODES, Chairman

APPROVED BY AGENCY: April 1, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held June 28, 2013, at 1:00 p.m., at the Office of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify the agency in writing by 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 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. Written comments shall be accepted until July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Lindsey Lane, Board Administrator, Kentucky Board of Registration for Professional Geologists, Division of Occupations and Professions, 911 Leawood Drive, P. O. Box 1360, Frankfort, Kentucky 40601, phone (502) 564-3296, ext. 228, fax (502) 696-4961.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Brian Judy

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the compensation for the board members for each day of actual board services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the compensation for the board members for each day of actual service.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to KRS 322A.020(7) by establishing the compensation for the board members within the parameters set out in statute.

(d) How this administrative regulation will assist in the effective administration of the statutes: This administrative regulation informs the public how much compensation a board member receives for board service.

(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: This amendment increases the compensation for board members for from $100 to $150. This increase reflects the first change in a board member's compensation since 1993.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to reflect current costs in operations.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to KRS 322A.020(7) by establishing the compensation for the board members within the parameters set out in statute.

(d) How the amendment will assist in the effective administration of the statutes: This amendment informs the public how much compensation a board member receives for board service.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are five (5) members of 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: The board members will be required to perform service for the board.

(b) In complying with this administrative regulation or amendment, how much will it cost for each of the entities: Not applicable.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Board members and the public will be informed how much compensation a board member receives for board service.

(5) Estimate of how much it will cost to implement this administrative regulation:

(a) Initially: Historically, the board has meet an average of eight (8) times per year. The cost per meeting will increase $250 per meeting, or $2000 per year.

(b) On a continuing basis: See above.

(6) The source of funding for the implementation and enforcement of this administrative regulation: The board is funded strictly from fees paid by applicants and licensees.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation: No increase in fees will be 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 or increase any fees.

(9) TIERING: Is tiering applied? Tiering was not applied as the compensation is paid to each board member.

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? Board of Registration for Professional Geologists.

2. Identify each state or federal statute or federal regulation that authorizes the action taken by the administrative regulation: KRS 322A.020(7, 322A.030.

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

(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? N/A

(c) How much will it cost to administer this program for the first year? Approximately $2000.

(d) How much will it cost to administer this program for subsequent years? Approximately $2000.

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 Registration for Professional Geologists
(Amendment)

201 KAR 31:040. Applications and Examinations.

RELATES TO: KRS 322A.030(3), (4), 322A.040(1)(c), 322A.045

STATUTORY AUTHORITY: KRS 322A.030(5)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322A.040(1)(c) requires administrative regulations governing the examination of applicants for registration. KRS 322A.045 requires the board to promulgate an administrative regulation governing the examination for an applicant for certification as a geologist-in-training. This administrative regulation outlines requirements concerning examinations.

Section 1. General Requirements. (1) The board shall furnish to applicants pertinent instructions and establish the examination schedule which shall include: the place, the time, and the final date by which the board shall have received the applicant's materials.

(2) An applicant for examination shall submit a complete application and pay the required application and examination fees to the board at the time of filing of the application[~~in a timely manner~~]. Once the application has been approved by the board, the applicant shall be scheduled to take the examination at the next regularly scheduled date.

(3) If an applicant fails to appear for the scheduled examination and presents a valid reason in writing no later than thirty (30) days after the missed examination date for missing the examination, such as illness or death in the immediate family, the examination may be deferred until the next scheduled date upon payment of a twenty-five (25) dollar fee[~~without forfeiture of the examination fee~~].

(4) If an applicant fails to appear for or to complete the examination without a valid reason, the applicant shall forfeit all examination fees paid.

(5) If an applicant fails to appear for a second scheduled examination, without presenting a valid reason in writing such as illness or death in the immediate family, the application shall be terminated on the date of the examination, and the applicant shall be denied registration on the basis of failure of the examination by default. The applicant may not engage in the public practice of geology or otherwise violate KRS 322A.090(2)[~~use the title "registered geologist"~~].

(6) An applicant who fails to complete the application and examination process within one (1) year of the date of filing of the application shall file a new application and pay the fees required by 201 KAR 31:010 in order to be eligible for registration or certification unless the applicant has obtained a deferral under 201 KAR 31:040.

Section 2. Examination for Registration. (1) An applicant for licensure shall submit to an examination composed of the Fundamentals of[~~in~~] Geology (FG) and the Practice of Geology (PG) developed and owned by the National Association of State Boards of Geology (ASBOG®). The applicant shall obtain a scaled score equal to passage of seventy (70) percent[~~of the test items~~] on both the Fundamentals of Geology (FG) and the Practice of Geology (PG) examinations[~~each portion of the examination~~].

(2) An applicant shall provide a current, government-issued, photographic identification at the time of the examination[~~An applicant for registration who has been approved to sit for the examination and whose supervisory arrangement has been approved by the board shall be considered to be functioning under a temporary permit until all requirements for registration have been completed~~].

(3) If an applicant for registration fails one (1) or both[~~portions~~] of the examinations[~~examination~~], the applicant may, with payment of the required fee, be rescheduled to take the examination at the[~~its~~] next regularly scheduled examination date. An applicant who fails one (1)[~~portion~~] of the examinations[~~examination~~] shall be required to retake only the examination[~~portion~~] on which the applicant failed to achieve a passing scaled score.

(4) If the applicant is practicing under a temporary permit, the applicant may continue to practice under the supervision of a registered geologist until achieving a passing score on the examination or until sixty (60) days after the second examination offered after the applicant has been approved for registration.

Section 3. Examination for Certification as a Geologist-in-Training. [~~(1)~~] An applicant for certification as a Geologist-in-Training:

(1)[~~(a)~~] Shall submit to an examination composed of the Fundamentals of[~~in~~] Geology (FG) developed and owned by the National Association of State Boards of Geology (ASBOG®);

(2)[~~(b)~~] Shall obtain a scaled score equal to passage of seventy (70) percent[~~of the test items on the examination~~];

(3)[~~(c)~~] Shall not[~~May~~] take this examination prior to[~~during~~] the applicant's final semester or quarter from an accredited college or university[~~year of approved undergraduate program having completed ninety (90) semester hours or 135 quarter hours of college course work~~].

Section 4. Incorporation[~~Incorporated~~] by Reference. (1) [~~Form~~] "Application for Registration as a Geologist", April 1, 2013[~~(September 1, 2005,~~] edition[~~)~~], is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright laws, at the Kentucky Board of Registration for Professional Geologists, 911 Leawood Drive, Frankfort, Kentucky 40601, (502) 564-3296, Monday through Friday, 8 a.m. to 5:00[~~4:30~~] p.m.

LARRY R. RHODES, Chairman

APPROVED BY AGENCY: April 1, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held June 28, 2013, at 1:00 p.m., at the Office of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify the agency in writing by 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 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. Written comments shall be accepted until July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Lindsey Lane, Board Administrator, Kentucky Board of Registration for Professional Geologists, Division of Occupations and Professions, 911 Leawood Drive, P. O. Box 1360, Frankfort, Kentucky 40601, phone (502) 564-3296, ext. 228, fax (502) 696-4961.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Brian Judy

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation governs the application and examination process.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the requirements concerning examination.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 322A.040(1)(c) requires administrative regulations governing the examination of applicants for registration.

(d) How this administrative regulation will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the statues by establishing the requirements concerning examination.

(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: This amendment governs the application and examination process.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to establish the requirements concerning examination.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 322A.040(1)(c) requires administrative regulations governing the examination of applicants for registration.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the statues by establishing the requirements concerning examination.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are approximately 1,500 individuals licensed by 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: Applicants will be required to meet the requirements of this administrative regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost for each of the entities: The cost of the examination and application are established in 201 KAR 31:010.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Applicants will be informed of the process for taking the examination.

(5) Estimate of how much it will cost to implement this administrative regulation:

(a) Initially: None.

(b) On a continuing basis: None.

(6) The source of funding for the implementation and enforcement of this administrative regulation: The Kentucky Board of Registration for Professional Geologists is funded from fees paid by licensees and applicants.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation: No increase in fees or funding will be 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 or increase any fees or directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied.

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? Board of Registration for Professional Geologists.

2. Identify each state or federal statute or federal regulation that authorizes the action taken by the administrative regulation: KRS 322A.030(5).

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

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 Registration for Professional Geologists
(Amendment)

201 KAR 31:050. Renewals.

RELATES TO: KRS 322A.060, 322A.070

STATUTORY AUTHORITY: KRS 322A.030(5), 322A.060, 322A.070

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322A.060 establishes conditions for the renewal, suspension, and revocation of certificates of registration. KRS 322A.070 authorizes the board to determine the initial and expiration dates for certificates of certification. KRS 322A.030(5) authorizes the board to promulgate administrative regulations required to perform its duties. This administrative regulation establishes procedures for the renewal of certificates of registration and certification.

Section 1. (1) A registered professional geologist or certified geologist-in-training shall[~~annually~~] before October 1 of each odd numbered year:

(a) File a completed renewal application; and

(b) Pay to the board the renewal fee established by 201 KAR 31:010, Section 3(1).

(2)(a) A certificate of registration that is not renewed before October 1 of each odd numbered year shall expire as provided by KRS 322A.060(1).

(b) A certificate[~~of certification~~] for a geologist-in-training that is not renewed before October 1 of each odd numbered year shall expire as provided by KRS 322A.070.

Section 2. A ninety (90) day grace period shall be allowed beginning October 1 of each odd numbered year, during which a registered professional geologist or certified geologist-in-training may:

(1) Continue to practice; and

(2) Renew his or her certificate of registration or certification by filing a completed renewal application and by paying[~~upon payment of~~] the renewal fee as provided by 201 KAR 31:010, Section 3(1).

Section 3. (1) A certificate of registration or certification that is not renewed before December 29 of each odd numbered year shall expire for non-renewal[~~be suspended for failure to renew~~].

(2) Upon expiration[~~suspension~~], the registered professional geologist or certified geologist-in-training shall:

(a) Not[~~be eligible to~~] practice geology in Kentucky[~~the Commonwealth~~];

(b) Be notified by the Board at the last known address available to the board of his or her expiration[~~suspension~~]; and

(c) Be instructed to cease and desist the public practice of geology in Kentucky.

Section 4. After the ninety (90) day grace period and before the end of two (2) years, a professional geologist or geologist-in-training expires[~~suspended~~] for failure to renew, may have his or her certificate of registration or certification reinstated upon:

(1) Payment of the reinstatement fee as provided by 201 KAR 31:010, Section 3(3);

(2) Completion of the Application for Reinstatement; and

(3) Documentation of employment and description of job duties from the time of expiration[~~suspension~~] until the date of the Renewal application[~~present~~].

Section 5. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Renewal Application for Registration as a Geologist", April 1, 2013[~~(September 1, 2005,~~] edition[~~)~~];

(b) "Renewal Application for Certification as a Geologist-in-Training", April 1, 2013[~~(September 1, 2005~~] edition[~~)~~];

(c) "Reinstatement Application for Registration as a Geologist", April 1, 2013[~~(September 1, 2005~~] edition[~~)~~]; and

(d) "Reinstatement Application for Certification as a Geologist-in-Training", April 1, 2013[~~(September 1, 2005~~] edition.[~~);~~]

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Registration for Professional Geologists, 911 Leawood Drive, Frankfort, Kentucky 40601, (502) 564-3296, Monday through Friday, 8 a.m. to 5:00[~~4:30~~] p.m.

LARRY R. RHODES, Chairman

APPROVED BY AGENCY: April 1, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held June 28, 2013, at 1:00 p.m., at the Office of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify the agency in writing by 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 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. Written comments shall be accepted until July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Lindsey Lane, Board Administrator, Kentucky Board of Registration for Professional Geologists, Division of Occupations and Professions, 911 Leawood Drive, P. O. Box 1360, Frankfort, Kentucky 40601, phone (502) 564-3296, ext. 228, fax (502) 696-4961.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Brian Judy

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation changes the renewal period from an annual renewal to a biennial renewal.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to implement the change to biennial renewal passed in the 2012 session of the General Assembly.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The biennial renewal period implemented by this administrative regulation is set out in KRS 322A.060.

(d) How this administrative regulation will assist in the effective administration of the statutes: This administrative regulation will inform licensees of the period for renewing a license.

(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 amendment changes the renewal period from an annual renewal to a biennial renewal.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to implement the change to biennial renewal passed in the 2012 session of the General Assembly.

(c) How the amendment conforms to the content of the authorizing statutes: The biennial renewal period implemented by this administrative regulation is set out in KRS 322A.060.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will inform licensees of the period for renewing a license.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administra-

tive regulation: There are approximately 1,500 individuals licensed by 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: Licensees will be required to renew a license in odd numbered years.

(b) In complying with this administrative regulation or amendment, how much will it cost for each of the entities: The renewal fee established by 201 KAR 31:010 remained the same per year, but is now to be collected every other year. Therefore, no increase in fees was implemented by this change.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Licensees will be able to renew a license biennially.

(5) Estimate of how much it will cost to implement this administrative regulation:

(a) Initially: No cost is anticipated to implement this administrative regulation.

(b) On a continuing basis: No cost is anticipated on a continuing basis.

(6) The source of funding for the implementation and enforcement of this administrative regulation: The board is funded by fees paid by licensees and applicants.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation: No increase in fees will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees. No fees are established directly or indirectly by this administrative regulation.

(9) TIERING: Is tiering applied? Tiering was not applied.

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 Kentucky Board of Registration for Professional Geologist.

2. Identify each state or federal statute or federal regulation that authorizes the action taken by the administrative regulation: KRS 322A.030(5), 322A.060, 322A.070.

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

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 Registration for Professional Geologists
(Amendment)

201 KAR 31:060. Code of professional conduct.

RELATES TO: KRS 322A.010, 322A.030(6), 322A.100

STATUTORY AUTHORITY: KRS 322A.030

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322A.030(6) requires the board to adopt by administrative regulation a code of professional conduct. KRS 322A.030(5) requires the board to promulgate administrative regulations necessary to conduct its responsibilities and duties. KRS 322A.100 authorizes the board to discipline registered professional geologist or geologist-in-training[~~registrants, including any person issued a certificate by the board~~]. This administrative regulation establishes a code of professional conduct, which includes a list of[~~actions considered to be~~] grounds for disciplinary action against a registered professional geologist or[~~registrant, including a registered geologist or certified~~] geologist-in-training.

Section 1.[~~Definition. "Registrant" means a "registered geologist" or a "geologist-in-training" as defined by KRS 322A.010(4) and (7).Section 2.~~] Public Trust and Welfare. (1) The public practice of geology requires professional ethical conduct and professional responsibility, as well as scientific knowledge on the part of the registered professional geologist or geologist-in-training[~~practitioner~~].

(2) A registered professional geologist or geologist-in-training[~~registrant~~] shall protect, to the fullest extent possible, the public health and welfare, and public and private property, in carrying out the public practice of geology.

Section 2[~~3~~]. Integrity in Professional Practice. (1) A registered professional geologist or geologist-in-training[~~registrant~~] shall be guided by the highest standards of ethics, honesty, integrity, personal honor, fairness, and professional conduct when engaged in the public practice of geology.

(2)[~~(a)~~] A registered professional geologist or[~~certified~~] geologist-in-training shall provide professional service only within his or her scope of competency as determined by education,[~~when qualified by~~] training, or experience in the technical areas involved.[~~(b) A registrant may practice under the supervision of another registered geologist for the purpose of obtaining training or experience in new technical areas.~~]

(3)[~~(a)~~] A registered professional[~~registrant~~] geologist or geologist-in-training shall:

(a) Render[~~exercise reasonable care when rendering~~] professional services and shall apply appropriate technical knowledge and skills consistent with the standards of the profession;[~~ordinarily applied by a registrant.~~]

(b)[~~A registrant shall~~] Distinguish between fact and opinion in all estimates, descriptions, locations, and evaluations provided;

(c) Document[~~; and set forth~~] all assumptions applied to estimates, descriptions, locations, and evaluations; and

(d)[~~. (4) A registrant when engaged in the public practice of geology, shall~~] Base his or her professional conclusions[~~opinions~~] upon empirical knowledge and commonly recognized geological principles.

(4)[~~(5)~~] A registered professional geologist or geologist-in-training[~~registrant~~] shall not use, issue, or provide[~~a false statement or~~] false, misleading, or deceptive information[~~or make sensational, exaggerated and unwarranted statements when engaged in the public practice of geology with the intent to mislead or deceive others~~].

(5)[~~(6)~~] A registered professional geologist shall sign and seal only professional work[~~, including, but not limited to, maps and reports~~] for which he or she[~~the registrant~~] has direct professional knowledge for which he or she shall be responsible[~~, and the registrant intends to be responsible for its accuracy and adequacy~~].

Section 3[~~4~~] Relationship of Registered Professional Geologists and Geologist-In-Training to Employer or Client. (1) A registered professional geologist and geologist-in-training[~~registrant~~]

shall provide adequate and accurate representation of his or her credentials, qualifications, and scope of responsibilities for all previous professional and academic experience[claimed] when negotiating with prospective employers or clients.

(2) A registered professional geologist and geologist-in-training[registrant] shall protect[,to the fullest possible extent,] the interest of his or her employer or client, and the confidentiality of information obtained from an employer or client[, so far as is consistent with the law and the geologist's professional obligations and ethics].

(3) It shall not be a violation of subsection (2) of this section, if a registered professional geologist or a geologist-in-training reports in good faith an immediate or potential danger to the health, safety, and welfare of the public to the appropriate federal, state, or local authority.

(4) A registered professional geologist or geologist-in-training[registrant] shall avoid conflict of interest with an employer or client and shall disclose the circumstances to the employer or client if a conflict exists[is unavoidable]. A registered professional geologist or geologist-in-training[registrant] shall disclose[make full disclosure] to all parties[of]:

(a) Any financial interest, compensation, or other value[transaction involving payments] made to any person for the purpose of securing a contract, assignment, or engagement;

(b) Any[monetary,] financial or beneficial interest the registered professional geologist or geologist-in-training has[registrant may have] in any contract or entity providing goods or services, other than[professional] services for the public practice of geology, to a project or engagement;

(c) Any financial interest, compensation, or other value[compensation or concurrent employment] from more than one (1) employer or client on the same or substantially similar project; or

(d) Any financial interest, compensation, or other value[owned or controlled mineral or other interest] which affects[may, either directly or indirectly, have a pertinent bearing on] the registered professional geologist or geologist-in-training[registrant's] employment[to the employer] or client.

(4) A registered professional geologist or geologist-in-training[registrant] in the public practice of geology shall not engage in fraud or material deception in the delivery of professional services, including reimbursement or[accept] compensation[without furnishing services].

(5) A registered professional geologist or geologist-in-training[registrant] shall give reasonable[due] notice of withdrawal of service from an employer or client except that the registered professional geologist or geologist-in-training[registrant] may withdraw without reasonable[due] notice if:

(a) The registered professional geologist or geologist-in-training[registrant] fails to receive adequate compensation, or has reasonable cause to believe that compensation for services performed will not be received;

(b) The registered professional geologist or geologist-in-training[registrant] knows, or has reasonable cause to believe, that continued employment will result in a violation of KRS Chapter 322A, the accompanying administrative regulations promulgated thereunder, or otherwise be in violation of local, state, or federal law[illegal];

(c) The registered professional geologist or geologist-in-training[registrant] knows, or has reasonable cause to believe, that the employer or client is in violation of local, state, or federal law[involved in illegal] or fraudulent, or deceptive practices, or practices dangerous to the public health and welfare or property; or

(d) The registered professional geologist or geologist-in-training[registrant] knows, or has reasonable cause to believe, that continued employment may[will] result in sickness or injury to the registered professional geologist, geologist-in-training, or third-parties who may be affected[, or the geologist's dependents].

Section 5. Relationship of Professional Geologists and Geologists-in-Training to[Other Professionals Engaged in the Public Practice of Geology and] Other Related Disciplines. (1) A registered professional geologist or geologist-in-training[registrant] shall:

(a)[freely] Give credit for work done by others to whom credit is due;

(b) Not plagiarize[and shall refrain from plagiarism in] oral and written communications;[,] and

(c) Not knowingly accept credit[rightfully] due another.

(2) A registered professional geologist or geologist-in-training[registrant] shall[either] engage, or advise an employer or client to engage, other experts or specialists if in the best interests of the employer or client[the client's interests are best served by this service].

(3) If a registered professional geologist or geologist-in-training[registrant] has knowledge or reasonable cause to believe another person or geologist is in violation of any provision of KRS Chapter 322A or the administrative regulations promulgated thereunder, the registered professional geologist or geologist-in-training shall file an initiating complaint pursuant to 201 KAR 31:090[present information in writing to the board].

(4) A registered professional geologist shall provide adequate supervision and training to other registered professional geologists or other geologists-in-training the registered professional geologist is supervising, and make them aware of this code of professional conduct.

Section 6. Grounds for Disciplinary Action. (1) A registered professional geologist, geologist-in-training, or applicant[registrant] shall not:

(a) Violate any provision of KRS Chapter 322A or the accompanying administrative regulations including this code of professional conduct;

(b) Issue a false, misleading, or deceptive statement or information, or make a sensational, exaggerated, or unwarranted statement while engaged in the public practice of geology;

(c) Defraud or deceive a client or employer while engaged in the practice of geology;

(d) Fail to comply with an order issued by the board;

(e) Fail to cooperate with the board by:

1. Unreasonably refusing to furnish a[paper or] document or other tangible evidence requested by the board;

2. Unreasonably refusing to furnish in writing a complete explanation covering a matter contained in a complaint against the registered professional geologist or geologist-in-training[registrant] filed with the board;

3. Not appearing before the board at a time and place designated by the board during the investigation of a complaint or hearing without good cause; or

4. Not properly responding to a subpoena issued by the board.

(f) Aide or abet an unregistered person or uncertified in the public practice of geology when registration or certification is required;

(g) 1. Be convicted of:

a. A felony; or

b. A misdemeanor which may impact that person's ability to engage in the public[related to the] practice of geology with reasonable care and skill;

2. Conviction shall include:

a. A finding or verdict of guilt;

b. An admission of guilt;

c. A plea of Alford or nolo contendere; or

d.[conviction based on:

a. A plea of nolo contendere or an Alford plea; or

b.] The suspension or deferral of a sentence; or

(h) Engage in the public practice of geology if the registered professional geologist or geologist-in-training may be impaired by a reason of a mental, physical, or other condition that impedes his or her ability to practice competently[while under any physical or mental disability, or other condition, so that continued practice may be dangerous to clients or to the public safety].

(2) A registered professional geologist shall not:

(a) Fail to provide adequate supervision to persons for whom the registered professional geologist is professionally responsible;

(b) Sign, seal, or stamp professional geological work not prepared under his or her direct professional knowledge, control or supervision.

LARRY R. RHODES, Chairman

APPROVED BY AGENCY: April 1, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held June 28, 2013, at 1:00 p.m., at the Office of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify the agency in writing by 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 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. Written comments shall be accepted until July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Lindsey Lane, Board Administrator, Kentucky Board of Registration for Professional Geologists, Division of Occupations and Professions, 911 Leawood Drive, P. O. Box 1360, Frankfort, Kentucky 40601, phone (502) 564-3296, ext. 228, fax (502) 696-4961.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Brian Judy

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation governs the conduct of professional geologists and geologists-in-training.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the code of professional conduct for licensees.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the authorizing statutes by establishing a professional code of conduct in accordance this KRS 322A.030(6).

(d) How this administrative regulation will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administrative of the statutes by establishing the code of professional conduct that must be followed by licensees in order to protect the public.

(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 amendment clarifies the code of professional conduct.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to clarify the requirements of the code of professional conduct.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the authorizing statutes by establishing a professional code of conduct in accordance this KRS 322A.030(6).

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administrative of the statutes by establishing the code of professional conduct that must be followed by licensees in order to protect the public.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are approximately 1,500 individuals licensed by 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: Licensees will be required to conform their professional activities to the requirements of this administrative regulation in order to protect the public.

(b) In complying with this administrative regulation or amendment, how much will it cost for each of the entities: No costs are associated with conforming to the code of professional code.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): By complying with the code of professional conduct, the entities identified in question (3) will be acting in a manner that protects the public.

(5) Estimate of how much it will cost to implement this administrative regulation:

(a) Initially: No initial costs will be required to implement the administrative regulation.

(b) On a continuing basis: No continuing costs will be required to implement the administrative regulation.

(6) The source of funding for the implementation and enforcement of this administrative regulation: The board is funded by fees paid by licensees and applicants.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation: No increase in fees or funding will be 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 directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied.

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 Registration for Professional Geologists.

2. Identify each state or federal statute or federal regulation that authorizes the action taken by the administrative regulation: KRS 322A.030.

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

(d) How much will it cost to administer this program for subsequent years? No costs will be required to administer this program.

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 Registration for Professional Geologists
(Amendment)

201 KAR 31:080. Geologist-in-training.

RELATES TO: KRS 322A.010(7), 322A.045(2), 322A.070(5)

STATUTORY AUTHORITY: KRS 322A.030(5), 322A.045(2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322A.070(5) authorizes the board to issue a certificate as a geologist-in-training to a person who pays the required fee and who, in the opinion of the board, meets the requirements established in KRS 322A.045. KRS 322A.010(7) authorizes the board to set the academic qualifications and establishes the examination and passing score required for certification as a geologist-in-training. KRS 322A.070(5) indicates that a person who is issued a certificate as a

geologist-in-training is entitled to certain rights and privileges while credentialed. KRS 322A.030(5) authorizes the board to promulgate administrative regulations necessary to the conduct of its responsibilities and duties. This administrative regulation establishes the examination, and the required passing score for certification, and establishes the rights and privileges relative to the practice of a geologist-in-training.

Section 1. Examination and Passing Score. (1) The examination required by KRS 322A.045(2) shall be the Fundamentals of[~~in~~] Geology (FG), developed and owned by the National Association of State Boards of Geology (ASBOG®).

(2) The passing score on the examination shall be seventy (70) percent.

Section 2. Rights and Privileges. A geologist-in-training shall:

(1) Prepare geologic reports, documents, or conduct any geological work only while[~~in the employment of, and~~] under the direct supervision of[~~,~~] a registered professional geologist;

(2) Clearly identify himself or herself on any geologic reports or documents and to the public as a "geologist-in-training";

(3) Limit his or her professional geologic work to the specific services for which he or she is competent based on professional, training, education, and experience; and

(4) Not provide supervision for a registered professional geologist or another geologist-in-training.

Section 3[~~5~~]. Incorporation by Reference. (1) "Application for a Certificate as a Geologist-in-Training", April 1, 2013[~~(September 1, 2005,~~] edition[~~)~~], is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Registration for Professional Geologists, 911 Leawood Drive, Frankfort, Kentucky 40601, (502) 564-3296, Monday through Friday, 8 a.m. to 5:00[~~4:30~~] p.m.

LARRY R. RHODES, Chairman

APPROVED BY AGENCY: April 1, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held June 28, 2013, at 1:00 p.m., at the Office of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify the agency in writing by 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 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. Written comments shall be accepted until July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Lindsey Lane, Board Administrator, Kentucky Board of Registration for Professional Geologists, Division of Occupations and Professions, 911 Leawood Drive, P. O. Box 1360, Frankfort, Kentucky 40601, phone (502) 564-3296, ext. 228, fax (502) 696-4961.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Brian Judy

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes requirements for geologist-in-training.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the rules governing geologist-in-training.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 322A.010(7) authorizes the board to establish the examination and passing score required for certification as a geologist-in-training. KRS 322A.030(5) authorizes the board to promulgate administrative regulations necessary to the conduct of its responsibilities and duties.

(d) How this administrative regulation will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing guidelines for a geologist-in-training.

(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: This amendment updates the required examination to reflect the name of the currently recognized examination, and establishes requirements for geologist in training.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to establish the rules governing geologist-in-training.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 322A.010(7) authorizes the board to establish the examination and passing score required for certification as a geologist-in-training. KRS 322A.030(5) authorizes the board to promulgate administrative regulations necessary to the conduct of its responsibilities and duties.

(d) How the amendment will assist in the effective administration of the statutes: This amendment assists in the effective administration of the statutes by establishing guidelines for a geologist-in-training.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are approximately 1,500 individuals licensed by 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:

(b) In complying with this administrative regulation or amendment, how much will it cost for each of the entities

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3):

(5) Estimate of how much it will cost to implement this administrative regulation:

(a) Initially: None.

(b) On a continuing basis: None.

(6) The source of funding for the implementation and enforcement of this administrative regulation: The Kentucky Board of Registration for Professional Geologists is funded from fees paid by licensees and applicants.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation: No increase in fees or funding will be 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 or increase any fees or directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied.

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 Registration for Professional Geologists.

2. Identify each state or federal statute or federal regulation that authorizes the action taken by the administrative regulation: KRS 322A.030(5), 322A.045(2).

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

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 Registration for Professional Geologists
(Amendment)

201 KAR 31:090. Complaint management process.

RELATES TO: KRS 322A.030(6), (7), (8), 322A.100(1)-(5)

STATUTORY AUTHORITY: KRS 322A.030(5)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 322A.030(8) allows any person or organization to file a complaint regarding[~~prefer charges of fraud, deceit, gross negligence, or~~] misconduct against any registered professional geologist, geologist-in-training[~~registrant, certificant~~], or applicant. KRS 322A.090(2) prohibits any person not registered by the board from practicing geology or using or otherwise assuming in any way any title or description tending to convey the impression that the person is a registered professional geologist. This administrative regulation establishes procedures for the investigation of a complaint received by the board.

Section 1. Definitions. (1) "Chair" means the chair or vice-chair of the board.

(2) "Charge" means a specific allegation contained in a Notice of Administrative Hearing[~~formal complaint~~], as established in subsection (4) of this section, issued by the board alleging a violation of a specified provision of KRS Chapter 322A or the administrative regulations promulgated thereunder.

(3) "Complaints committee" means the committee appointed pursuant to Section 7 of this administrative regulation.

(4) "Notice of Administrative Hearing[~~Formal complaint~~]" means a formal administrative pleading authorized by the board which sets forth charges against a registered professional geologist, geologist-in-training[~~registrant, certificant~~], or applicant,[~~or other person~~] and commences a formal disciplinary proceeding pursuant to KRS Chapter 13B[~~or requests the court to take appropriate action~~].

(5) "Informal proceeding" means a proceeding instituted before, during, or after the disciplinary process with the intent of reaching a disposition[~~dispensation~~] of a matter[~~without further recourse to formal disciplinary procedures under KRS Chapter 13B or appropriate relief in the courts~~].

(6) "Initiating complaint" means a written statement[~~allegation~~] alleging possible misconduct by a registered professional geologist, geologist-in-training, applicant,[~~credentialed individual~~] or other person which might constitute a violation of KRS Chapter 322A or the administrative regulations promulgated thereunder.

(7) "Investigator" means an individual designated by the board to assist the board in the investigation of a complaint[~~or an investigator employed by the Attorney General or the board. (8) "Registrant" means a "registered geologist" or a "geologist-in-training" as defined by KRS 322A.010(4) and (7)~~].

Section 2. Receipt of Initiating Complaints. (1)(a) An initiating complaint may be submitted by an individual, organization,[~~or~~] entity, or the board based on information in its possession.

(b) An initiating complaint shall be in writing and shall be signed by the person offering the initiating complaint.[~~(c) The board may file an initiating complaint based on information in its possession.~~]

(2) Upon receipt of an initiating complaint.

(a) A copy of the initiating complaint shall be sent to the individual named in the initiating complaint, along with a request for that individual's response to the initiating complaint.

(b) The individual shall submit a written response within twenty (20) days from the date of receipt.

Section 3. Initial Review. (1)(a) After the receipt of an initiating complaint and the expiration of the period for the individual's response, the complaints committee shall consider the initiating complaint, the individual's response, and other relevant material available and make a recommendation to the board.

(b) The board shall determine whether there is enough evidence to warrant an[~~a formal~~] investigation of the initiating complaint.

(2) If, in the opinion of the board, an initiating complaint does not warrant an[~~a formal~~] investigation of the initiating complaint, the board shall dismiss the initiating complaint and shall notify both the complaining party and the individual of the outcome of the initiating complaint.

(3) If, in the opinion of the board, an initiating complaint warrants an[~~a formal~~] investigation against either a registered professional geologist, geologist-in-training,[~~individual~~] or a person who may be practicing without appropriate credential, the board shall authorize an investigator to investigate the matter and make a report to the complaints committee[~~at the earliest opportunity~~].

Section 4. Results of Formal Investigation; Board Decision on Hearing. (1)(a) Upon completion of an[~~the formal~~] investigation, the investigator shall submit a report to the complaints committee of the facts regarding the initiating complaint.

(b) The complaints committee shall review the investigative report and make a recommendation to the board.

(c) The board[~~bard~~] shall determine whether there is enough evidence to believe that a violation of the law or administrative regulations may have occurred and whether a Notice of Administrative Hearing[~~formal complaint~~] shall be filed.

(2)(a) If, in the opinion of the board, an initiating complaint does not warrant the issuance of a Notice of Administrative[~~formal complaint and the holding of a~~] Hearing, the initiating complaint shall be dismissed or other appropriate action taken.

(b) The board shall notify both the complaining party and the individual of the outcome of the initiating complaint.

(3)[~~(a) When in the opinion of the board an initiating complaint warrants the issuance of a formal complaint against a registrant, the complaints committee shall prepare a formal complaint which states clearly the charge or charges to be considered at the hearing.~~

~~(b) The formal complaint shall be signed by the chair or designee and served upon the individual as required by KRS 13B.040. (4)~~] If, in the opinion of the board, a person may be practicing without appropriate credential, the board may:

(a) Issue a letter ordering that person to cease and desist from the uncredentialed practice of geology or using any words or phrases prohibited by KRS 322A.090(2); or

(b) Forward information to the county attorney of the county of residence of the person allegedly practicing without appropriate credential with a request that appropriate action be taken under KRS 322A.990(1)-(2).

Section 5. Settlement by Informal Proceedings; Letter of Admonishment. (1) The board, through counsel and the complaints committee, may enter into informal proceedings with the individual who is the subject of the initiating complaint for the purpose of appropriately dispensing with the matter.

(a) An agreed order or settlement reached through this process shall be approved by the board and signed by the individual who is the subject of the initiating complaint.

(b) The board may employ mediation as a method of resolving the matter informally.

(2)(a) The board may issue a written admonishment to the registered professional geologist or geologist-in-training[~~registrant~~]

if in the judgment of the board:

1. An alleged violation is not of a serious nature; and

2. The evidence presented to the board after the investigation and appropriate opportunity for the registered professional geologist or geologist-in-training[~~registrant~~] to respond, provides a clear indication that the alleged violation did in fact occur.

(b) A copy of the admonishment shall be placed in the permanent file of the registered professional geologist or geologist-in-training[~~registrant~~].

(c) Within thirty (30) days of receipt of a written admonishment, the registered professional geologist or geologist-in-training[~~registrant~~] may file:

1. A response to the written admonishment which shall be placed in the registered professional geologist's or geologist-in-training's[~~registrant's~~] permanent file; or

2. A request for hearing with the board. Upon receipt of this request, the board shall set aside the written admonishment and set the matter for hearing pursuant to the provisions of KRS Chapter 13B.

Section 6. Notice and Service Process. A notice required by KRS Chapter 322A or this administrative regulation shall be issued pursuant to KRS 13B.040.

Section 7. Complaints Committee. The Complaints Committee shall:

(1) Be appointed by the chair of the board to:

(a) Review an initiating complaint or investigative report; and

(b) Participate in an informal proceeding to resolve a formal complaint;

(2) Consist of two (2) board members, who may be assisted by board staff, an investigator, and counsel.

LARRY R. RHODES, Chairman

APPROVED BY AGENCY: April 1, 2013

FILED WITH LRC: May 15, 2013 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held June 28, 2013, at 1:00 p.m., at the Office of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify the agency in writing by 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 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. Written comments shall be accepted until July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Lindsey Lane, Board Administrator, Kentucky Board of Registration for Professional Geologists, Division of Occupations and Professions, 911 Leawood Drive, P. O. Box 1360, Frankfort, Kentucky 40601, phone (502) 564-3296, ext. 228, fax (502) 696-4961.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Brian Judy

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation sets forth the complaint process.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the complaint process.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 322A.030(6) and (7) authorizes the board to promulgate regulations to establish a professional code of conduct and take appropriate disciplinary action, respectively.

(d) How this administrative regulation will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the statutes by establishing the code of professional conduct and the disciplinary process.

(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: This amendment governs the code of professional conduct and the disciplinary process.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to establish the code of professional conduct and the disciplinary process.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 322A.040(1)(c) requires administrative regulations governing the examination of applicants for registration.

(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 establishing the requirements concerning the code of professional conduct and the disciplinary process.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are approximately 1,500 individuals licensed by 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: The changes in the Amendment do not impose any new requirements or burdens on the approximately 1,500 individuals licensed by the board.

(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 regulated entities identified in question (3) are provided an opportunity to respond to any complaint filed and due process if evidence is found to support a violation of state law.

(b) In complying with this administrative regulation or amendment, how much will it cost for each of the entities: No new costs are associated with the changes to the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): By complying with the amendment, the entities identified in question (3) will be provided with due process in the complaint process.

(5) Estimate of how much it will cost to implement this administrative regulation:

(a) Initially: None

(b) On a continuing basis: None

(6) The source of funding for the implementation and enforcement of this administrative regulation: The Kentucky Board of Registration for Professional Geologists is funded from fees paid by licensees and applicants.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation: No increase in fees or funding will be 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 or increase any fees or directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied.

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? Board of Registration for Professional Geologists.

2. Identify each state or federal statute or federal regulation that authorizes the action taken by the administrative regulation: KRS 322A.030(5), 322A.050, 322A.060(1), 322A.070(1), (3).

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

(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? N/A

(c) How much will it cost to administer this program for the first year? N/A

(d) How much will it cost to administer this program for subsequent years? N/A

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 2:251. Hunting and trapping seasons and limits for furbearers.

RELATES TO: KRS 150.170, 150.180,[~~150.360,~~] 150.370, 150.399, 150.400, 150.415, 150.416, 150.990

STATUTORY AUTHORITY: KRS 150.025(1), 150.175(7), (9), 150.360(6), 150.410

NECESSITY, FUNCTION, AND CONFORMITY: 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 methods of take,[~~to regulate any method of taking,~~] and to make these[~~those~~] requirements apply to a limited area. KRS 150.175(7), (9) authorizes the department to issue licenses, permits, and tags for hunting and trapping. KRS 150.410 authorizes the department to regulate trap tags, trap visitation, and trap placement to protect domestic animals. KRS 150.360(6) authorizes the department to promulgate administrative regulations establishing the requirements for hunting coyotes at night with or without the use of lights or other means designed to make wildlife visible at night. This administrative regulation establishes seasons, bag limits, and legal methods for hunting and trapping furbearers.

Section 1. Definitions. (1) "Body-gripping trap" means a commercially manufactured spring-loaded trap designed to kill the animal upon capture.

(2) "Dry land set" means a trap that is not set to submerge an animal in water upon capture.

(3) "Foothold trap" means a commercially manufactured spring-loaded trap with smooth, metallic or rubber soft-catch jaws that close upon an animal's foot.

(4) "Furbearer" means mink, muskrat, beaver, raccoon, opossum, gray fox, red fox, least weasel, long-tailed weasel, river otter, bobcat, coyote, and striped skunk.

(5) "Hunter" means a person hunting furbearers with gun, gun and dog, bow and arrow, dog, or by falconry.

(6) "Otter Zone 1" means the following counties: Anderson, Ballard, Bath, Boone, Bourbon, Bracken, Breckinridge, Bullitt, Caldwell, Calloway, Campbell, Carlisle, Carroll, Christian, Crittenden, Daviess, Fayette, Fleming, Franklin, Fulton, Gallatin, Grant, Graves, Grayson, Hancock, Hardin, Harrison, Henderson, Henry, Hickman, Hopkins, Jefferson, Kenton, Larue, Livingston, Lyon, Marshall, Mason, McCracken, McLean, Meade, Muhlenberg, Nelson, Nicholas, Ohio, Oldham, Owen, Pendleton, Robertson, Rowan, Scott, Shelby, Spencer, Trigg, Trimble, Union, Webster, and Woodford.

(7) "Otter Zone 2" means all Kentucky counties not included in subsection (6) of this section.

(8) "Snare" means a wire, cable, or string with a knot, loop, or a single piece closing device which is not power or spring assisted.

(9) "Squaller" means a hand-operated, mouth-operated, or electronic call capable of mimicking the vocalizations of furbearers.

(10) "Trap" means a body-gripping trap, box trap, deadfall, foothold trap, snare, or wire cage trap used to catch furbearers.

(11) "Water set" means a trap set to submerge an animal in water upon capture.

(12) "Youth" means a person who has not reached sixteen (16) years of age.

Section 2. Harvest Methods for Furbearers. Unless specified in Section 3(9) of this administrative regulation, a person shall only use the following to take furbearers:

(1) Centerfire gun;

(2) Rimfire gun;

(3) Shotgun;

(4) Bow and arrow;

(5) Crossbow; or

(6) An air gun using pellets at least .22 caliber in size.

Section 3. Hunting Requirements. (1) Unless exempted by KRS 150.170, a person shall carry proof of purchase of a valid hunting license while hunting furbearers.

(2) Furbearers may be taken during daylight hours only, except for the following, which can also be taken after daylight hours:

(a) Coyote;

(b) Opossum; or

(c) Raccoon[~~and opossum~~].

(3) [~~Raccoon and opossum may be taken day or night, except that~~] A person shall not take raccoon or opossum[~~raccoons or opossums~~] during daylight hours during the modern gun deer season, as established in 301 KAR 2:172.

(4) A hunter in a boat shall not use a light[~~from a boat~~] to take raccoon or opossum.

(5) A person shall not use the following while chasing raccoon or opossum from noon on March 1 through September 30;

(a) A firearm;

(b) Slingshot;

(c) Tree climber; or

(d) Any device to kill, injure, or force a raccoon or opossum from a tree or den.

(6) A person may use a squaller year-round.

(7) There shall not be a closed season on:

(a) Chasing red and gray foxes during daylight hours for sport and not to kill; and

(b) Chasing raccoons or opossums for sport and not to kill.

(8) A hunter may use a hand or mouth-operated call, electronic call, or any other attracting device during a furbearer hunting season.

(9) A person may take a coyote after daylight hours, with the following restrictions:

(a) A person shall not use artificial light or other means designed to make wildlife visible at night from June 1 through January 31;

(b) Any artificial light or other means designed to make wildlife visible at night shall not be connected to or cast from a mechanized vehicle;

(c) A person shall not use any weapon other than a shotgun; and

(d) A person shall not use shot shells with a single projectile.

Section 4[~~3~~]. Trapping Requirements. (1) Unless exempted by KRS 150.170, a person shall carry proof of purchase of a valid trapping license while trapping.

(2) A person who is trapping on dry land shall not:

(a) Set traps closer than ten (10) feet apart; or

(b) Use any trap except for the following:

1. Deadfall;

2. Wire cage or box trap;

3. Foothold trap with a maximum inside jaw spread of six (6) inches measured perpendicular to the hinges;

4. Body-gripping trap with a maximum inside jaw spread of seven and one-half (7.5) inches measured parallel with the trigger; or

5. A snare.

(3) There shall be no restrictions on the size or type of trap used as a water set.

(4) A trap shall not be set in a trail or path commonly used by a human or a domestic animal.

(5) A trapper may use lights from a boat or a vehicle.

Section 5[~~4~~]. Trap Tags. (1) Each trap shall have a metal tag attached to it that clearly shows one (1) of the following:

(a) The name and address of the person setting, using, or maintaining the trap; or

(b) A wildlife identification number issued by the department and the 1-800-25ALERT department hotline phone number.

(2) A person may apply for a wildlife identification number by:

(a) Accessing the department's Web site at www.fw.ky.gov; or

(b) Calling the department's information center at 1-800-858-1549.

(3) The following information shall be required for a person to apply for a wildlife identification number:

(a) Name;

(b) Current home address;

(c) Social Security number;

(d) Current phone number;

(e) Date of birth; and

(f) Driver's license number, if available.

(4) A person shall:

(a) Not use a trap tag that has an inaccurate or outdated address;

(b) Not use a trap tag that has a wildlife identification number that corresponds to an inaccurate or outdated address or phone number; and

(c) Contact the department to provide updated address and phone number.

(5) A wildlife identification number is valid for the life of the holder.

Section 6[~~5~~]. Hunting Season Dates. Except as specified in 301 KAR 2:049 or 301 KAR 2:125, a person shall not take the following wildlife except during the dates specified in this section:

(1) Bobcat: from noon on the fourth Saturday in November through the last day of February.

(2) Coyote: year round.

(3) Raccoon and Opossum: October 1 through the last day of February.

(4) All other furbearers: from noon on the third day of the modern gun deer season through the last day of February.

(5) Furbearers taken by falconry: September 1 through March 30.

Section 7[~~6~~]. Trapping Season Dates. Except as specified in 301 KAR 2:049 or 301 KAR 2:125, a person shall not take furbearers except from noon on the third day of the modern gun deer season through the last day of February.

Section 8[~~7~~]. License-Exempt Season for Youth. For seven (7) consecutive days beginning on the Saturday after Christmas, a youth may hunt or trap furbearers without a license, but all other statewide requirements shall apply.

Section 9[~~8~~]. Bag Limits. There shall not be a bag limit on furbearers except:

(1) A person shall not take more than five (5) bobcats per season, no more than three (3) of which shall be taken with a gun;

(2) A person shall not take more than ten (10) river otters per season in Otter Zone 1;

(3) A person shall not take more than six (6) river otters per season in Otter Zone 2;

(4) The total river otter bag limit per season shall be ten (10) per person, only six (6) of which can be taken from Otter Zone 2; and

(5) A falconer hunting within the falconry season, but outside the dates specified in Section 6(3)[~~5(3)~~] and (4) of this administrative regulation, shall not take more than two (2) of any furbearer per day.

Section 10[~~9~~]. Harvest Recording. (1) Immediately after taking a river otter or bobcat, and before moving the carcass, a person shall record in writing the following information:

(a) The species;

(b) The date;

(c) The county where taken; and

(d) The sex of the animal.

(2) The information listed in subsection (1) of this section shall be recorded on one of the following:

(a) The hunter's log section on the reverse side of a license or permit;

(b) The hunter's log section in the current hunting and trapping guide;

(c) A hunter's log available from any KDSS agent; or

(d) An index card or similar card.

(3) A person shall retain and possess the completed hunter's log while hunting or trapping during the current season.

Section 11[~~10~~]. Checking a River Otter or Bobcat. (1) A person who takes a river otter or bobcat shall:

(a) Check each animal by calling the toll free number listed in the current hunting and trapping guide on the day the river otter or bobcat is harvested;

(b) Provide the information requested by the automated check-in system; and

(c) Write the confirmation number provided by the automated check-in system on the hunter's log described in Section 10[~~9~~] of this administrative regulation.

(2) A person who intends to sell the raw fur of a river otter or bobcat to a licensed fur processor, fur buyer, or taxidermist or wishing to export a river otter or bobcat pelt outside the United States shall:

(a) Contact the department and request a Convention on International Trade of Endangered Species of Flora and Fauna (CITES) tag by providing:

1. A valid confirmation number as described in subsection (1) of this section; and

2. A street address where the tag is to be mailed; or

(b) Access the department's Web site at www.fw.ky.gov and complete and submit the CITES tag request form to the department.

(3) A person who intends to transfer to another person a river otter or bobcat that does not have an attached CITES tag shall attach to the carcass a handmade tag that contains the following:

(a) The confirmation number;

(b) The hunter or trapper's name; and

(c) The hunter or trapper's phone number.

(4) A person shall not provide false information when:

(a) Completing the hunter's log;

(b) Checking a river otter or bobcat; or

(c) Creating a handmade carcass tag.

(5) A CITES tag shall be attached to the raw fur, pelt, or unskinned carcass per the instructions provided by the department and remain with the pelt until it is processed or exported outside the United States.

(6) Possession of an unused CITES tag is prohibited unless authorized by the department.

Section 12[~~11~~]. Transporting and Processing a River Otter or Bobcat. (1) A person shall not sell the raw fur of a river otter or bobcat except to a licensed:

(a) Fur buyer;

(b) Fur processor; or

(c) Taxidermist.

(2) A taxidermist, fur buyer, or fur processor shall:

(a) Not accept a river otter or bobcat carcass or any part of a river otter or bobcat without a proper carcass tag or CITES tag described in Section 11[~~10~~] of this administrative regulation; and

(b) Keep the following information from a hunter or trapper:

1. Name;

2. Address;

3. Confirmation number or CITES tag number; and

4. Date received for each river otter or bobcat.

DR. JONATHAN GASSETT, Commissioner
MARCHETA SPARROW, Secretary

APPROVED BY AGENCY: March 8, 2013

FILED WITH LRC: May 14, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on

June 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 July 1, 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 regulation establishes furbearer hunting and trapping seasons, bag limits, legal methods of take, and other furbearer hunting and trapping requirements.

(b) The necessity of this administrative regulation: This regulation is necessary to provide adequate furbearer hunting and trapping opportunities and to properly manage furbearer populations 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 establishing open seasons for the taking of wildlife, to regulate bag limits, to regulate any method of taking, and to make these requirements apply to a limited area. KRS 150.175(7),(9) authorizes the department to issue licenses, permits, and tags for hunting and trapping. KRS 150.410 authorizes the department to regulate trap tags, trap visitation, and trap placement to protect domestic animals. Chapter 29 of the 2013 Acts of the General Assembly authorizes the department to promulgate administrative regulations which allow coyote hunting after daylight hours.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in administering the above statutes by defining the seasons, bag limits, and methods of take for furbearers in Kentucky.

(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 establishes a year-round night-time hunting season for coyotes. Hunters may use lights or other means to make coyotes visible at night from February 1 through May 31. This amendment also prohibits the use of artificial light and night-vision equipment by coyote hunters when operating a mechanized vehicle, restricts weapon use to shotguns, and prohibits the use of single projectile ammunition when hunting coyotes after daylight hours. This amendment also establishes weapon restrictions for the take of furbearers.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to allow increased opportunity for the harvest of coyotes in Kentucky. As coyotes have spread throughout the eastern U.S., interest in predator hunting has exhibited a dramatic increase over the last ten (10) years. Landowners suffering depredation from coyotes will be able to employ night hunting as a removal tool. Hunting at night can be an effective practice as coyotes are generally less wary than during daylight hours. The establishment of minimum weapon restrictions will prohibit the use of firearms that are not sufficient for the effective harvest of furbearers.

(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 statutes: See (1)(d) above.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All those who hunt or trap furbearers could potentially benefit from these regulatory amendments. Landowners who are suffering coyote damage may also benefit. There is not a current estimate for the number of hunters who pursue coyotes in Kentucky.

(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: Legal hunters may now pursue and take coyotes after daylight hours on a year-round basis; however, hunters may only use artificial light or other means designed to make wildlife visible at night from February 1 through May 31. Artificial light or other means designed to make wildlife visible shall not be connected to or cast from a mechanized vehicle when hunting coyotes after daylight hours. Night hunting for coyotes is limited to shotguns only using a shot shell that does not contain a single projectile. In addition, any person hunting furbearers with an air rifle shall only use pellets of .22 caliber and greater.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Hunters that pursue coyotes will collectively benefit from these amendments that establish a night-time hunting season when coyotes are generally less wary and more susceptible to harvest. Landowners suffering livestock depredation from coyotes will significantly benefit from these amendments that allow the legal year-round harvest of coyotes at night.

(5) 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 department to implement this administrative regulation.

(b) On a continuing basis: There will be no additional cost to the department 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.

(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: It will not be necessary to increase any other fees or to increase funding 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 fees or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? No. Tiering is not applied because all hunters of furbearers in Kentucky must comply with the requirements of this 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 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), 150.175(7), (9), 150.410, and Chapter 29 of the 2013 Acts of the General Assembly.

(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 additional revenue will be 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? No additional revenue will be generated by this administrative regulation during subsequent years.

(c) How much will it cost to administer this program for the first year? There will be no additional costs incurred for the first year.

(d) How much will it cost to administer this program for subsequent years? There will be no additional costs incurred 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:

EDUCATION AND WORKFORCE DEVELOPMENT CABINET
Department of Workforce Investment
Office of Employment and Training
(Amendment)

787 KAR 1:010. Application for employer account; reports.

RELATES TO: KRS 341.190

STATUTORY AUTHORITY: KRS 151B.020, 341.115

NECESSITY, FUNCTION, AND CONFORMITY: KRS 341.190(1) requires each employing unit to keep specified work records and authorizes the secretary to require additional reports. This administrative regulation establishes the application requirements for an employer account and the requirements for other additional reports required by the division.

Section 1. Each employing unit that has met one (1) or more of the requirements for coverage set forth in KRS 341.070 shall complete and file with the Division of Unemployment Insurance an [“]Application for Unemployment Insurance Employer Reserve Account[”] UI-1 no later than the last day of the calendar quarter in which the coverage requirements are first met.

Section 2. Each employing unit shall complete and file with the Division of Unemployment Insurance the following reports as required in accordance with the instructions contained on the forms:

(1) UI-1S, [“]Supplemental Application for Unemployment Insurance Employer Reserve Account[”];

(2) UI-3, [“]Employer's Quarterly Unemployment Wage and Tax Report[”];

(3) UI-3.2, [“]Account Status Information[”];

(4) UI-21, [“]Report of Change in Ownership or Discontinuance of Business in Whole or Part[”]

(5) UI-35, [“]Termination of Coverage[”];

(6) UI-74, [“]Application for Partial Payment Agreement[”];

(7) UI-412A, [“]Notice to Employer of Claim for Unemployment Insurance Benefits[”]; and

(8) UI-203, [“]Overpayment and Fraud Detection[”].

Section 3. If an employing unit elects to submit the information required in any report listed in Section 1 or 2 of this administrative regulation through the Web site provided by the Division of Unemployment Insurance for that purpose, the requirement for the filing of that report shall have been satisfied.

Section 4. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) UI-1, "Application for Unemployment Insurance Employer Reserve Account”, Rev. 3/05;

(b) UI-1S, "Supplemental Application for Unemployment Insurance Employer Reserve Account”, Rev. 5/11;

(c) UI-3, "Employer's Quarterly Unemployment Wage and Tax Report”, Rev. 4/13[~~5/11~~];

(d) UI-3.2, "Account Status Information”, Rev. 5/11;

(e) UI-21, "Report of Change in Ownership or Discontinuance of Business in Whole or Part”, Rev. 3/05;

(f) UI-35, "Termination of Coverage”, Rev. 5/11;

(g) UI-74, "Application for Partial Payment Agreement”, Rev. 5/11;

(h) UI-203, "Overpayment and Fraud Detection”, Rev. 9/11; and

(i) UI-412A, "Notice to Employer of Claim for Unemployment Insurance Benefits”, Rev. 9/11.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of the Director of Unemployment Insurance, 275 E. Main Street, 2E, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

BUDDY HOSKINSON, Executive Director

APPROVED BY AGENCY: May 10, 2013

FILED WITH LRC: May 14, 2013 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on June 21, 2013 at 10:00 a.m. at the offices of the Office of Employment and Training, 275 E. Main Street, 2nd floor, Executive Director’s Office, Frankfort, Kentucky 40621. Individuals interested in being heard at this hearing shall notify this agency in writing by June 14, 2013, 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 July 1, 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: Buddy Hoskinson, Executive Director, Office of Employment and Training, 275 East Main, 2C, Frankfort, Kentucky 40602, phone (502) 564-533, fax (502) 564-7452.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Buddy Hoskinson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the application requirements for an employer account and the requirements for other additional reports required by the Division of Unemployment Insurance ("division").

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the necessary reports an employer is required to file with the division.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 341.190(1) requires each employing unit to keep specified work records and authorizes the secretary to require additional reports. In addition, KRS 341.115(1) authorizes the secretary to promulgate administrative regulations necessary in the administration of KRS Chapter 341.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation sets required forms an employer is required to file with the division.

(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 incorporates the updated UI-3 form. It will allow the division to enforce KRS 341.614.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary because beginning January 1, 2014, a surcharge will be imposed on all subject contributing employers due to insufficient funds in the unemployment compensation administration fund.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 341.115 authorizes the secretary to promul-

gate administrative regulations deemed necessary or suitable for the proper administration of KRS Chapter 341.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will allow more efficient/effective notification to employers and collection of surcharge in accordance with KRS 341.614.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There are approximately 85,000 active contributory employer accounts in Kentucky. This change will provide notification of the surcharge being imposed and aid in overall compliance. The Office of Employment and Training will be responsible for updating the current processing system to accommodate this request.

(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 Office of Employment and Training will need to provide technical resources to accommodate the necessary programming updates. The Division of Unemployment Insurance will be responsible for mailing the quarterly unemployment wage and tax report. The employer will be required to complete the necessary reports.

(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 an additional cost associated to the employer of approximately twenty-one (21) dollars per employee that is paid the full taxable wage base for the year. The Office of Employment and Training will be responsible for funding the technical upgrades. The costs associated with the technical upgrades will be negligible and absorbed in the course of normal operating expenses.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The employer will receive notice of the correct surcharge rate associated with the current taxable wage base amount.

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

(a) Initially: Changes will be necessary to the processing system. These programming changes will be negligible costs and absorbed in the course of normal operating expenses.

(b) On a continuing basis: There is no 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? Unemployment Insurance is entirely federally funded. Unemployment Insurance administrative funds will be used to make the necessary programming changes.

(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 will be no fees necessary for this change. The unemployment insurance program is entirely federally funded and any technical changes necessary will be funded by unemployment insurance administrative funds.

(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 or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? This amendment updates the quarterly unemployment wage and tax report to notify employers the correct taxable wage base amount and surcharge amount. The amendment will be applied uniformly to all contributory employers and tiering is not applicable.

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? KRS 341.614 will only impact those employers who have elected to pay quarterly unemployment taxes. Most government agencies elect to simply reimburse for benefits paid out in lieu of paying quarterly taxes.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 341.070, KRS 341.250(2), KRS 341.190, and KRS 341.262.

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 an additional cost associated to the employer of approximately twenty-one (21) dollars per employee that is paid the full taxable wage base for the year. The estimated amount the surcharge will generate for 2014 is $31.7 million.

(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? Effective January 1, 2015, and each calendar year thereafter, the secretary of the Education and Workforce Development Cabinet shall adjust the surcharge percentage rate based on any increase to the taxable wage base for that calendar year. The purpose of the adjustment shall be to maintain costs per worker comparable to the original surcharge (approximately twenty-one (21) dollars per employee).

(c) How much will it cost to administer this program for the first full year? Implementation of this amendment will create no additional administrative costs in the first full year.

(d) How much will it cost to administer this program for subsequent years? There will be no additional costs 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 (+/-): None

Expenditures (+/-): None

Other Explanation:

EDUCATION AND WORKFORCE DEVELOPMENT CABINET
Department of Workforce Investment
Office of Employment and Training
(Amendment)

787 KAR 1:290. Contract construction rates.

RELATES TO: KRS 341.070, 341.272

STATUTORY AUTHORITY: KRS 341.115

NECESSITY, FUNCTION, AND CONFORMITY: KRS 341.272(1) requires entities engaged in the contract construction trades to pay contributions equal to the maximum rate of contributions under KRS 341.270. KRS 341.115(1) authorizes the secretary to promulgate administrative regulations to implement KRS Chapter 341. This administrative regulation establishes requirements for contract construction for the purposes of rate assignment under KRS 341.272.

Section 1. For the purpose of rate assignment, a service shall be considered as contract construction if the service is listed in the United States North American Industry Classification System Manual, 2012[~~2002~~], under Major Section 23, Subsections 236, 237, and 238.

Section 2. To be considered a contract construction employer, one-half (1/2) or more of the service upon which liability is established under KRS 341.070 shall be in contract construction.

Section 3. Incorporation by Reference. (1) "United States North American Industry Classification System Manual", 2012[~~2002~~], Major Section 23, Subsections 236, 237 and 238, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, sub-

ject to applicable copyright law, at the Education and Workforce Development Cabinet[~~for Workforce Development~~], Tax Status and Accounting Branch, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

BUDDY HOSKINSON, Executive Director

APPROVED BY AGENCY: May 10, 2013

FILED WITH LRC: May 14, 2013 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on June 21, 2013 at 11:00 a.m. at the offices of the Office of Employment and Training, 275 E. Main Street, 2nd floor, Executive Director's Office, Frankfort, Kentucky 40621. Individuals interested in being heard at this hearing shall notify this agency in writing by June 14, 2013, 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 July 1, 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: Buddy Hoskinson, Executive Director, Office of Employment and Training, 275 East Main, 2C, Frankfort, Kentucky 40602, phone (502) 564-5331, fax (502) 564-7452.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Buddy Hoskinson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the requirement that entities engaged in contract construction trades pay contributions equal to the maximum rate of contributions under KRS 341.270. The regulation further sets forth the method by which an entity is determined to "be engaged in a contract construction trade." Currently, the regulation incorporates the 2002 Edition of the United States North American Industry Classification System (NAICS) Manual as a reference for making the determination. If the service provided by the entity is listed in Major Section 23, Subsections 236, 237, and 238, thereof, it is considered contract construction.

(b) The necessity of this administrative regulation: This administrative regulation presently uses the NAICS Manual to determine whether service is considered a "contract construction trade." The 2002 NAICS Manual has been incorporated by reference into the regulation. In order to receive federal funds to administrate portions of its research and statistics programs, the state must use the NAICS manual for assigning classifications. This amendment is necessary due to revisions of the NAICS Manual as set forth in the latest edition (2012 Edition).

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 341.272 requires that any new domestic corporations or any foreign corporations authorized to do business in this state, or any other legal entity engaged in the contract construction trade shall pay contributions equal to the maximum contribution rate under the rate schedule. The statute authorizes the contribution rate and the regulation conforms to the statute by determining the NAICS Manual shall be used to determine those entities covered under the statute.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation establishes the method for determining entities engaged in contract construction. The regulation identifies the entities that will be required to pay contribution rates for contract construction trades as required by the 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 amendment will update the document incorporated by reference into the current version of the administrative regulation. The amendment will incorporate the 2012 edition of the NAICS Manual, the most recent version.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary due to revisions of the NAICS Manual as set forth in the 2012 Edition.

(c) How the amendment conforms to the content of the authorizing statutes: The statute authorizes the contribution rate for contract construction trades and the regulation conforms to the statute by determining the NAICS Manual shall be used to determine those entities covered under the statute.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will facilitate more accurate classification of entities engaged in contract construction trades by using the most recent edition of the NAICS Manual with any updated information regarding contract construction classifications. The use of the updated edition will make classification uniform and consistent with all states that use the NAICS Manual as the method for classification of contract construction services and trades.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Entities engaged in contract construction trades will be affected by this administrative regulation. There are 9,070 employers currently identified as providing services under contract construction. The number of individuals affected is approximately 69,500.

(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: If an entity is classified as a contract construction trade, its contribution rate will be set at the maximum rate under KRS 341.270. The entity will be required to pay its contributions at that rate. The change will not affect those entities already identified and paying contributions under the contract construction rate.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The cost will be the amount of the contributions based on the maximum contribution rate. The change will not affect those entities already identified and paying contributions under the contract construction rate.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The contributions will be included in the entity's unemployment insurance reserve account for use in paying unemployment insurance claims charged against the entity.

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

(a) Initially: There will be nominal costs associated with the implementation of the change.

(b) On a continuing basis: There will be nominal costs associated with the implementation of this change on a continuing basis.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation? Unemployment Insurance administrative funds will be used to make any necessary implementation changes.

(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 will be no fees necessary for this change. Any technical changes necessary will be funded by unemployment insurance administrative funds.

(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 or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applicable because all taxpayers identified by the regulation are treated the same.

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? Only those employers who have elected to pay quarterly unemployment taxes will be impacted. Most government employers elect to reimburse benefits paid out in lieu of paying quarterly taxes.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 341.272.

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 additional revenue will be generated with the implementation of this administrative regulation 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 additional revenue will be generated with the implementation of this administrative regulation for subsequent years.

(c) How much will it cost to administer this program for the first full year? Implementation of this amendment will create no additional administrative costs in the first full year.

(d) How much will it cost to administer this program for subsequent years? There will be no additional costs to implement 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 (+/-): None

Expenditures (+/-): None

Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Maternal and Child Health
(Amendment)

902 KAR 30:001. Definitions for 902 KAR Chapter 30.

RELATES TO: KRS 200.650-200.676, 20 U.S.C. Chapter 33[~~1431-1444~~], 34 C.F.R. Part 303

STATUTORY AUTHORITY: KRS 194A.050, 200.660

NECESSITY, FUNCTION, AND CONFORMITY: KRS 200.660 requires the Cabinet for Health and Family Services to administer all funds appropriated to implement provisions, to enter into contracts with service providers, and to promulgate administrative regulations necessary to implement KRS 200.650 to 200.676. This administrative regulation establishes the definitions for 902 KAR Chapter 30 pertaining to First Steps, Kentucky's Early Intervention Program.

Section 1. Definitions. (1) "Ability to pay" means a family has an income at 200 percent of the poverty level or above.

(2) "Assessment" means the ongoing procedures used by appropriate qualified service providers throughout the child's period of eligibility in First Steps to identify:

(a) The child's unique strengths and needs, and the services appropriate to meet those needs;

(b) The resources, priorities, and concerns of the family; and

(c) The supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability.

(3)[~~(2)~~] "Assistive technology device" means any item, piece of equipment, or product system:

(a) Whether acquired commercially off the shelf, modified, or customized;

(b) That is needed to:

1. Increase, maintain, or improve the functional capabilities of a child with a disability; and

2. Implement the individualized family service plan; and

(c) Except for a medical device that is surgically implanted, including a cochlear implant, or the optimization (e.g. mapping), maintenance, or replacement of that device[~~, whether acquired commercially off the shelf, modified, or customized, that is needed to increase, maintain, or improve the functional capabilities of a child with a disability and which is necessary to implement the individualized family service plan~~].

(4)[~~(3)~~] "Assistive Technology Service" means a service that directly assists the child with a disability in the selection, acquisition, or use of an assistive technology device in accordance with 20 U.S.C. 1401(2).

(5)[~~(4)~~] "Cabinet-approved criterion referenced instrument" means any of the three (3) assessments, incorporated by reference in 902 KAR 30:120, used to assess children from birth to three (3) years of age.

(6)[~~(5)~~] "Cabinet-approved screening protocol" means a screening protocol that is:

(a) Designed to evaluate the developmental status of children; and

(b) Used by the cabinet.

(7)[~~(6)~~] "Child find" is defined by KRS 200.654(3).

(8) "Consent" is defined by 34 C.F.R. 303.7.

(9) "Destruction" means the physical destruction of the record or ensuring that personal identifiers are removed so that the record is no longer personally identifiable under 34 C.F.R. 303.29.

(10)[~~(7)~~] "Direct supervision" means the continuous, on-site observation and guidance as activities are implemented with children and families.

(11)[~~(8)~~] "District Early Intervention Committee" or "DEIC" is defined by KRS 200.654(6).

(12) "Early intervention record" means all records, electronic and hard copy, regarding a child that are required to be collected, maintained, or used under part C of the Individuals with Disabilities Education Act, 20 U.S.C. 1400-1482, and 902 KAR Chapter 30.

(13) "Early intervention service provider" is defined by 34 C.F.R. 303.12.

(14)[~~(9)~~] "Early intervention services" is defined by 34 C.F.R. 303.13[~~KRS 200.654(7)~~].

(15)[~~(10)~~] "Established risk" means a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

(16)[~~(11)~~] "Evaluation" means the use of procedures to determine eligibility for First Steps services in accordance with 902 KAR 30:120.

(17)[~~(12)~~] "Family-centered" means practices that:

(a) Are driven by the family's priorities and concerns;

(b) Support the family's role as the constant in a child's life;

(c) Complement a family's natural activity settings and daily routines; and

(d) Support, respect, encourage, and enhance the strengths, competence, and confidence of the family.

(18)[~~(13)~~] "First Steps" means Kentucky's early intervention system, which is defined by KRS 200.654(8).

(19)[~~(14)~~] "First Steps data management system" means the online data system that consists of each child's early intervention record and financial management data.

(20)[~~(15)~~] "Homeless child" means a child who meets the federal definition of homeless children and youths established in 42 U.S.C. 11434a(2).

(21) "Inability to pay" means a family's income is below 200 percent of the poverty level.

(22)[~~(16)~~] "Indirect supervision" means the regular, periodic, on-site observation and guidance as activities are implemented with children and families.

(23)[~~(17)~~] "Individualized family service plan" or "IFSP" means an individual family service plan as defined by 34 C.F.R. 303.340[~~KRS 200.654(9)~~].

(24) "Initial assessment" means the assessment of the child and family assessment conducted prior to the child's first IFSP meeting.

(25)[~~(18)~~] "Kentucky Early Childhood Data System" or "KEDS" means the internet based[~~a web-based~~] data collection system to provide data for analysis to determine the degree to which Kentucky's children are meeting the major child outcomes and learning standards required by the Office of Special Education Programs (OSEP) in the United States Department of Education and the state early childhood standards.

(26)[~~(19)~~] "Multidisciplinary team" is defined by 34 C.F.R. 303.24[~~KRS 200.654(11)~~].

(27)[~~(20)~~] "Natural environments" is defined by 34 C.F.R. 303.26[~~means settings, such as the home and the community, in which the child's same age peers who have no disability normally participate~~].

(28)[~~(21)~~] "Parent" means:

(a) A natural, adoptive, or foster parent of a child;

(b) A guardian, except for the state if the child is a ward of the state[~~(but not the state if the child is a ward of the state)~~];

(c) An individual acting in the place of a natural or adoptive parent including a grandparent, stepparent, or other relative with whom the child lives, or an individual who is legally responsible for the child's welfare; or

(d) An individual assigned as a surrogate parent pursuant to 20 U.S.C.[~~1415(b)(2) or~~] 1439(a)(5).

(29)[~~(22)~~] "Part C Coordinator" means the individual designated by the cabinet to be Kentucky's liaison with the federal Department of Education, Office of Special Education Programs (OSEP) to oversee the state's implementation of the early intervention system.

(30) "Participating provider or agency" is defined by 34 C.F.R. 303.403(c).

(31)[~~(23)~~] "Period of eligibility" means the time from referral to First Steps to termination of services due to:

(a) Failure to meet initial program eligibility requirements;

(b) Attainment of age three (3);

(c) Documented refusal of service by the child's parent or legal guardian, inclusive of disappearance; or

(d) Change of residence to another state.

(32)[~~(24)~~] "Point of entry" or "POE" is defined by KRS 200.654(12).

(33)[~~(25)~~] "Prematurity" means a gestational age, at birth, of less than thirty-seven (37) weeks.

(34) "Primary referral source" is defined by 34 C.F.R. 303.302(c) and 34 C.F.R. 303.303(c).

(35)[~~(26)~~] "Primary service provider" means a professional who is a member of the IFSP team and is selected by the parent as the team lead to provide regular support to the family.

(36)[~~(27)~~] "Qualified service provider" means a provider who meets the qualifications listed in 902 KAR 30:150[~~is defined by KRS 200.654(13)~~].

(37)[~~(28)~~] "Record review team" means a group of early intervention experts representing each discipline of early intervention providers as listed in 902 KAR 30:150, Section 2(1)(a)-(r)[~~(s)~~], who are utilized by the state lead agency to review complex cases for eligibility and service provision, and make recommendations to IFSP teams.

(38)[~~(29)~~] "Referral" means a child identified between birth and three (3) years of age who is:

(a) A Kentucky resident or a homeless child within the boundaries of the Commonwealth; and

(b) Suspected of having an established risk diagnosis or a developmental delay[~~as confirmed by the cabinet approved screening protocol~~].

(39)[~~(30)~~] "State Lead Agency" means the designated staff in the Department for Public Health who are responsible for implementing the First Steps Program in accordance with 34 C.F.R. 303.22[~~Part 303~~], 20 U.S.C. Chapter 33[~~1431 to 1444~~], and KRS 200.650 to 200.676.

(40)[~~(31) "Transdisciplinary team" means professionals from various disciplines working together cooperatively by educating one another in the skills and practices of their disciplines and a commitment to work together across traditional discipline boundaries being consistent with the training and expertise of the individual team members. (32)~~] "Ward of the state" means a child declared by a circuit court judge to be a ward of the state pursuant to KRS 625.043(2) or 625.100(2).

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

APPROVED BY AGENCY: May 14, 2013

FILED WITH LRC: May 15, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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

(1) Provide a brief summary of 902 KAR 30:001:

(a) What this administrative regulation does: This administrative regulation provides definitions unique to the early intervention system as defined by Pub.L. 108-446, the Individuals with Disabilities Education Improvement Act.

(b) The necessity of this administrative regulation: 902 KAR 30:001 is necessary to define specific terminology used in the early intervention system.

(c) How this administrative regulation conforms to the content of the authorizing statute: KRS 200.650 requires that the Cabinet for Health and Family Services be in compliance with federal law.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation is needed to provide 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 adds the following definitions: ability to pay, early intervention provider, early intervention record and destruction, inability to pay, participating provider or agency and primary referral source. The amendment expands the following definitions: assessment, assistive technology device. The term transdisciplinary team is deleted from this regulation.

(b) The necessity of the amendment to this administrative regulation: KRS 200.650 (6) requires compliance with federal law. KEIS needs to update the state regulations to stay in compliance with the updated federal regulations, 34 C.F.R. Part 303 released in September 2011.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment adds or expands the definitions related to early intervention services to conform with the updated definitions in federal regulation.

(d) How the amendment will assist in the effective administration of the statutes: These amendments will help to assure compliance with federal statute and regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by the administrative regulation: Approximately 1,500 early intervention providers, including Point of Entry staff, will be affected by these 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: Regulated entities will continue to provide early intervention services as they currently practice.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There are no additional costs to entities to comply with the amended regulations.

(c) As a result of the compliance, what benefits will accrue to the entities identified in question (3): Early intervention providers will be eligible for continued funding and participation in First Steps.

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

(a) Initially: There are no costs to implement this regulation.

(b) On a continuing basis: There are no costs to implement 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, state general funds, and Medicaid funds are used to support the early intervention system.

(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 this is an amendment: No increase in fees or funding is necessary to implement this amended administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increase any fees? No, this administrative regulation does not directly or indirectly increase any 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 fifteen (15) local Point of Entry offices, 1,500 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. Chapter 33, 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. This administrative regulation provides clarification of program terms.

(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 revenues generated by this administrative regulation during 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 expenditures to implement this administrative regulation during the 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: There is no fiscal impact on local or state government for this administrative regulation.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal Statute or regulation constituting the federal mandate. 34 C.F.R. 303 Subpart A—General list the definitions commonly used in early intervention services. As a recipient of federal Part C monies, Kentucky Early Intervention Services is mandated to fully comply with all federal statutes. The changes in the definitions bring KEIS into full compliance with this federal statute and are required for continued receipt of those funds.

2. State compliance standards.KRS 200.650 charges the Cabinet for Health and Family Services and the Department for Public Health to comply with federal law as it pertains to services for infants and toddlers with disabilities and their families.

3. Minimum or uniform standards contained in the federal mandate. By revising this administrative regulation to mirror the federal language regarding definitions the state will be in full compliance under this part of the federal statute.

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

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Maternal and Child Health
(Amendment)

902 KAR 30:110. Point of Entry and service coordination.

RELATES TO: KRS 200.662, 200.664, 200.668, 200.670,[~~20 U.S.C. 1400, 1435,~~] 34 C.F.R. 303.34, 303.164, 303.165, 303.167, 303.342, 303.344,[~~and~~] 303.403, 303.421, 20 U.S.C. 1400, 1435, 42 U.S.C. 280g-1, 701, 1381, 1396, 1397, 5106, 9801, 10401, 15001-15009

STATUTORY AUTHORITY: KRS 194A.050, 200.660(8)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 200.660[~~250.660~~] requires the Cabinet for Health and Family Services to administer all funds appropriated to implement provisions, to enter into contracts with service providers, and to promulgate administrative regulations necessary to implement KRS 200.650 to 200.676. This administrative regulation establishes the point of entry and service coordination provisions pertaining to First Steps, Kentucky's Early Intervention Program.

Section 1. Point of Entry. (1)(a) The point of entry (POE) staff shall serve as the local lead agency and shall coordinate child find efforts with:

1. Programs authorized under part B of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C 1400[~~Local education agencies in order to insure compliance with child find mandates by each entity~~]; and

2. Other state and federal programs serving this population.

(b) The primary referral sources described in paragraph (a) of this subsection may include:

1. Maternal and child health programs, including the Maternal, Infant and Early Childhood Home Visiting Program, under Title V of the Social Security Act (42 U.S.C 701(a));

2. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) under Title XIX of the Social Security Act (42 U.S.C 1396(a)(43) and 1396(a)(4)(B))[~~Early and periodic screenings, diagnosis, and treatment (EPSDT) programs~~];

3. Head Start, including Early Head Start programs under section 645A of the Head Start Act (42 U.S.C. 9801);

4.[~~Homeless shelters;~~

~~5.~~] Supplemental Security Income (SSI) programs under Title XVI of the Social Security Act (42 U.S.C 1381);

5. Child protection and child welfare programs, including programs administered by and services provided through the foster care agency and the state agency responsible for administering the Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C. 5106(a));

6.[~~The local Department for Community Based Services (DCBS) office for cases with a sustained or negligent complaint; and~~

~~7.~~]Programs authorized through 42 U.S.C 15001 to 15009, the Developmental Disabilities Assistance and Bill of Rights Act;

7. Child care programs;

8. Programs that provide services under the Family Violence Prevention and Services Act (42 U.S.C. 10401);

9. Early Hearing Detection and Intervention (EDHI) systems (42 U.S.C. 280g-1) administered by the Centers for Disease Control (CDC);

10. The Children's Health Insurance Program (CHIP) authorized under Title XXI of the Social Security Act (42 U.S.C. 1397aa); and

11. Hospitals and physicians.

(2) Each POE staff shall maintain accessibility and provide public awareness activities in each of their districts.

(3) The POE staff shall maintain communication with the District Early Intervention Committee (DEIC) and the state lead agency on matters of child find, service options, and other issues relevant to the First Steps Program.

(4) The POE staff shall accept all referrals[~~inquiries~~] for First Steps services to determine eligibility for programs.

(a) Upon receiving a telephone or written referral[~~inquiry~~], POE staff shall determine if:

1. The family is aware that a referral[~~an inquiry~~] is being made; and

2. The referral is appropriate based on:

a. The child's age, which shall be between birth and three (3) years old;

b. The family's residence within the assigned district or the family being homeless; and

c. An established risk diagnosis or a developmental concern[~~that is confirmed by administration of the cabinet approved screening protocol~~].

(b) A child who is referred due to a developmental concern, and not screened by the primary referral source, shall have a cabinet approved screening protocol completed prior to the initial evaluation.

(c) If the point of entry[~~initial screening~~] finds the child does not meet the criteria established in paragraph (a)2. of this subsection, the POE shall [~~:~~

~~1.~~] provide to the referral source appropriate resources for the child and family for services that meet that child's needs. These resources may include:

1.[~~a.~~] Public schools;

2.[~~b.~~] The Department for Community Based Services;

3.[~~c.~~] Medical services;

4.[~~d.~~] Other appropriate community services; or

5.[~~e.~~] Another POE if residency alone is the reason for an inappropriate referral[~~; and~~

~~2. Provide a parent with a First Steps Notice of Action or a First Steps Notice of Action and Consent in accordance with 34 C.F.R. 303.403(b)~~].

(d)[~~(c)~~] If it is determined that the child meets the criteria established in paragraph (a)2. of this subsection, POE staff shall contact the family by telephone or letter within five (5) working[~~three (3) calendar~~] days of receipt of the referral to provide information about the program and obtain consent for intake[~~determine if the family would like more information and an initial visit scheduled~~].

(e) For a child referred due to an established risk condition, if[~~(d)~~] the family is interested in early intervention services, the POE staff shall assign a service coordinator and continue with the intake process.

(f) For a child referred due to a developmental concern that has been confirmed by administration of the cabinet approved screening protocol, if the family is interested in early intervention services, the POE staff shall assign a service coordinator and continue with the intake process.

(g) The parent or guardian of a child referred due to a developmental concern shall:

1. Be provided with prior written notice of the POE's intent to administer the cabinet approved screening protocol. The notice shall include the option to request an evaluation at any time during the screening procedure; and

2. Give written consent prior to the administration of the cabinet approved screening protocol.

(h)[~~(e)~~] If the family is not interested in participating, the family shall be provided contact information for the POE and other community resources. The POE staff shall document in the child's record the refusal of services.

(i) If the POE staff is unable to contact the family within five (5) working days from the date of the referral, a follow-up letter shall be sent to the family and the case closed.

(j) If the POE is able to contact the family initially but the family fails to return the screening protocol or consent, the POE shall send a First Steps Notice of Action (FS-9) and close the case five (5) working days from the date of notice[~~(f) Within fifteen (15) working days of the referral, the POE staff shall send, in writing, an acknowledgment to the referral source that the referral was received and the status of the processing of the referral, if known at that time~~].

(5) All children who are two (2) years and ten and one-half (10 1/2) months old to age three (3) years when first referred to First Steps shall not be eligible for First Steps. The POE shall notify the parent or guardian in writing that due to the child's age at the time of referral, the First Steps Program will not provide an evaluation to determine eligibility for First Steps, but with written consent will refer the child to the state and[~~will connect the parent or guardian with the~~] local education agency or other community resource.

(6) The POE staff shall maintain a complete record on all children referred through the POE and provide data to the state lead agency as requested. A complete record shall include:

(a) A hard copy of all documents that include a parent signature;

(b) Any correspondence generated by the POE; and

(c) The data entered into the child's electronic early intervention record in the First Steps data management system.

(7) The POE staff shall provide data as requested by the DEIC.

Section 2. Service Coordination. (1) The service coordinator shall serve as the main point of contact in helping families obtain the services and assistance they need.

(2) During the intake process[~~initial visit to the family~~], the service coordinator shall:

(a) Identify the purpose of the visit;

(b) Discuss the role of the service coordinator;

(c) Explain the First Steps service delivery system, including:

1. The consultative model and primary service provider; and

2. The First Steps system of payment, which includes:

a. The family share participation fee; and

b. The billing of public and private insurance for early intervention services;

(d) Interview the family and document findings related to:

1. The parent or guardian's developmental concern for the child; and

2. The pregnancy, birth, and health information;

(e) Explain the family rights by reviewing the Family Rights Handbook;

(f) Discuss the forty-five (45) day timeline and determine the next action needed to determine eligibility for the child;

(g) Discuss evaluation and service options;

(h) Obtain parent or guardian signature on the First Steps Consent to Release/Obtain Information (FS-10) form for medical and developmental information;

(i) Collect insurance information and data necessary for billing and obtain parent or guardian signature on the Notice and Consent for Use of Private Insurance (FS-12A) form; and

(j) Assess the family's ability to pay using the Financial Assessment Verification (FS-13) form[~~(c) Explain the family rights by~~

~~reviewing the Family Rights Handbook and the Statement of Assurances – Procedural Safeguards;~~

~~(d) Obtain the signature of a parent or guardian on the Statement of Assurances – Procedural Safeguards;~~

~~(e) Obtain consent for an initial evaluation as required by 902 KAR 30:180, Section 2(3);~~

~~(f) Request the First Steps Consent to Release/Obtain Information form be completed by a parent or guardian for medical or developmental information, risk indicators, or other diagnostic or hearing test results;~~

~~(g) Determine the willingness of the family to participate in First Steps services or refusal of services;~~

~~(h) Interview the family and document findings relating to:~~

~~1. The child's developmental status;~~

~~2. The pregnancy, birth, and health information;~~

~~3. Social relationships;~~

~~4. Context for learning, including the family's history, resources, priorities, and concerns; and~~

~~5. The family's daily routines and activities, the family's satisfaction level with these routines, and the family's desired outcomes;~~

~~(i) Determine the next action needed with the family to determine eligibility of the child;~~

~~(j) Discuss evaluation and service options;~~

~~(k) Establish the potential date for developing an Individual Family Service Plan (IFSP);~~

~~(l) Discuss the role of the service coordinator; and~~

~~(m) Collect insurance information and data necessary for billing~~].

(3) The service coordinator shall:

(a) Assist the parents of infants and toddlers with disabilities obtain access to needed early intervention services and other services identified in the IFSP, including making referrals to providers for needed services and scheduling appointments for infants and toddlers with disabilities and their families;

(b) Coordinate the provision of early intervention services and other services, including educational, social, or medical services that are not provided for diagnostic or evaluative purposes, that the child needs or is being provided;

(c) Coordinate evaluations and assessments;

(d) Facilitate and participate in the development, review, and evaluation of IFSPs;

(e) Conduct referral and other activities to assist families in identifying available early intervention service providers;

(f) Coordinate, facilitate, and monitor the delivery of early intervention services to ensure that the services are provided in a timely manner;

(g) Conduct follow-up activities to determine that appropriate early intervention services are being provided;

(h) Coordinate the funding sources for service;

(i) Facilitate the development of a transition plan to preschool, school, or, if appropriate, to other services;

(j) Provide written confirmation in accordance with 34 C.F.R. 303.342(d)(2) to the parent or guardian and all IFSP team members[~~Notify parents, in accordance with the parental prior notice requirements of 34 C.F.R. 303.403, and all the IFSP team members in writing~~] of the date, time, and location of the meetings for the initial and annual Individual Family Service Plan (IFSP), the six (6) month review, and any other IFSP team meeting or the transition conference within[~~no less than~~] seven (7) calendar days prior to the IFSP, review, or transition conference date;

(k)[~~. (b)~~] If there is a cancellation of an IFSP meeting, notify the IFSP members in writing of the rescheduling of the IFSP meeting within five (5) working days of the cancelled meeting date;

(l) Reassess the family's ability to pay at the six (6) month review and annual IFSP meeting, and at other times if requested by the family; and

(m) Following the IFSP meeting[~~(c) Facilitate the initial, annual and six (6) month review IFSP meetings and any IFSP meetings requested to address revisions. The service coordinator shall~~]:

1. Enter all IFSP data into the First Steps data management system;

2. Finalize the plan within five (5) working days of the date of the meeting;

3. Provide a written copy to the parent or guardian within five (5) working days of the meeting and provide copies to persons identified and consented to by the family;

4. Refer the family to appropriate agencies for service identified on the IFSP in accordance with 902 KAR 30:130, Section 2(5)(i); and

5. Ensure that transition steps and services are discussed with the family during each IFSP meeting.

(4) The service coordinator shall inform the family of the family's rights and procedural safeguards by:

(a) Summarizing the Family Rights Handbook at the initial IFSP, at each subsequent IFSP, and at any time the family requests;

(b) Familiarizing the family with the procedural safeguards at every IFSP meeting[~~and due process rules, and ensuring that the family reviews and signs the Statement of Assurances – Procedural Safeguards at every IFSP review~~];

(c) Ensuring that all materials are given to the family in a format the family can understand in the family's native language; and

(d) Assisting the family, at the family's request, with resolving conflicts among service providers.

(5) The service coordinator shall assist the family in identifying available service providers by:

(a) Keeping current on all available services in the district; and

(b) Having available to the families a list of all eligible First Steps services providers in each district. If the family chooses a service provider outside the First Steps approved provider list, the service coordinator shall inform the family that the provider is not approved through First Steps and may result in a cost to the family.

(6)The service coordinator shall ensure that service coordination is available to families during normal business hours and at the family's request.

(7) The service coordinator shall contact the child's family at a minimum of one (1) time per plan to discuss service coordination needs, unless otherwise stipulated in the IFSP.

(8) The service coordinator shall give the family a business address and phone number and any other information needed to contact the service coordinator.

(9) If a family desires a change in the family's service coordinator, the family shall contact the POE and the POE shall seek to resolve the situation.

(10) The service coordinator shall facilitate the development of a transition plan by:

(a) Knowing the transition procedures as established in 902 KAR 30:130, Section 3(4)(f)[~~2(8)(l)~~];

(b) Ensuring that all potential agencies and programs that could provide service to a particular child after the age of three (3) are included when introducing the parents to future program possibilities;

(c) Holding a transition conference at least ninety (90) calendar days and, at the discretion of all parties, not more than nine (9) months prior to the child's third birthday. The transition conference shall involve the family, IFSP team, the special education local school district representative, and staff from potential next placement options; and

(d) Including at least one (1) transition outcome as a part of every IFSP that is consistent with 34 C.F.R. 303.344(h).

(11) The service coordinator shall ensure that all contacts with the family or other service providers are documented in the child's record in the First Steps data management system. This documentation shall occur within five (5)[~~seven (7)~~] days of the date of service and include:

(a) The date of contact;

(b) Amount of time spent;

(c) Reason for contact;

(d) Type of contact whether by telephone or face-to-face;

(e) Result of contact; and

(f) Plan for further action.

(12) The service coordinator shall document in[~~as notes on~~] the First Steps data management system all contacts attempted but not made[~~, and the reason if services were not delivered in a timely manner~~].

(13) The service coordinator shall encourage the family to access all services identified on the individualized family service

plan.

(14) If the family wants to voluntarily terminate a service or all services, the service coordinator shall:

(a) Document in the child's record which services are ending and the date of termination; and

(b) Send a follow-up letter that meets the requirements for prior written notice as specified in 34 C.F.R. 303.421[~~403~~] to the family which includes what services are terminating, and the date services will terminate, within five (5)[~~seven (7)~~] working days after notice from the family of the family's choice to end services.

(15) If the family is absent from a scheduled service with no prior notice for two (2)[~~at least three (3)~~] consecutive visits, the service provider shall notify the service coordinator[~~within seven (7) working days~~] after the last absence. If the service coordinator receives notice of no show from a provider, the service coordinator shall:

(a) Document the service provider's contact and try to make contact with the family to discuss the circumstances. The service coordinator shall:

1. If contact is made, notify each provider[~~within seven (7) working days~~] of the result of the discussion; or

2. If unable to contact the family within five (5) working days, send the family a notice of action without consent to indicate service will be terminated within seven (7) days of the date of the notice[~~no contact is made, send the family a letter within seven (7) working days:~~

~~a. Requesting direction as to the choice of the family in continuation of services;~~

~~b. Stating that the service will be discontinued until a choice is made by the family by contacting the service coordinator; and~~

~~c. Stating that if no contact is made by the family, services will be terminated fifteen (15) working days from the date of the letter~~]; and

(b) Notify the service provider, in writing, if services are terminated and the date of termination.[~~(16) The service coordinator shall be responsible for securing any Release of Information necessary to send or secure information, upon request from other service providers, including non First Steps providers involved in the care of the child.~~

~~(17) The service coordinator shall provide data to the cabinet upon request.~~

~~(18) The service coordinator shall limit practice in First Steps to service coordination only.~~]

Section 3.[~~Determination of Child's Hearing Status. (1) If the referral is for a birth to three (3) year old child who Is "at risk" as confirmed by the Early Hearing Detection and Intervention Data Base and the "at risk" indicator is the only reason the child was referred to First Steps, and no audiological evaluation has been performed, the family or guardian shall be notified to contact the child's primary health care provider, pediatrician, or an Approved Infant Audiological Assessment and Diagnostic Center as specified by KRS 211.647 and 216.2970 for an audiological evaluation to determine hearing status.~~

~~(2) If the referral is for a birth to three (3) year old child who is suspected of having a hearing problem, but not suspected of having any developmental problems, the family or guardian shall be notified to contact the child's primary health care provider, pediatrician, or an Approved Infant Audiological Assessment and Diagnostic Center as specified by KRS 211.647 and 216.2970 for an audiological evaluation to determine hearing status.~~

~~(3) If the referral is for a birth to three (3) year old child who has a diagnosis of significant hearing loss, as specified by KRS 200.654(10)(b), the child shall be considered to have an "established risk" diagnosis and be eligible for First Steps services and the referral process shall continue.~~

~~(4) If the referral is for a birth to three (3) year old child who is suspected of having a hearing loss, with no verification of degree of loss or diagnosis, and who is suspected of having delays in developmental areas, the POE staff shall initiate the evaluation for First Steps, which shall include an audiological evaluation at an Approved Infant Audiological Assessment and Diagnostic Center as specified by KRS 211.647 and 216.2970.~~

~~Section 4~~]. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Family Rights Handbook", December 2010;

(b) "First Steps Notice of Action (FS-9)", September 2012[~~December 2010~~];

(c)[~~"First Steps Notice of Action and Consent", December 2010;~~

~~(d)~~] "First Steps Consent to Release/Obtain Information (FS-10)", May 2012;

(d) "Financial Assessment Verification (FS-13)", May 2012[~~December 2010~~]; and

(e) "Notice and Consent for Use of Private Insurance (FS-12A)" May 2012[~~"Statement of Assurances – Procedural Safeguards", December 2010~~].

(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: May 14, 2013

FILED WITH LRC: May 15, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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

(1) Provide a brief summary of 902 KAR 30:110:

(a) What this administrative regulation does: This administrative regulation provides guidance and requirements for the Point of Entry (POE). The Point of Entry is the local lead agency that is responsible for public awareness activities, processing all referrals to the Kentucky Early Intervention System and is responsible for ongoing record keeping and service coordination activities.

(b) The necessity of this administrative regulation: This regulation is necessary to provide guidance to the POE regarding primary referral sources and the processing of referrals for early intervention services. The role of service coordinators has been expanded in regulation to comply with federal regulations. The service coordinator is responsible for coordinating all services for an eligible child and family and this regulation sets the process for the development of this plan.

(c) How this administrative regulation conforms to the content of the authorizing statute: KRS 200.652 (2-6) requires that there be an operational early intervention system. KRS 200.664 requires an individualized family service plan be developed for all eligible infants and toddlers. KRS 200.670 requires KEIS to implement public awareness activities to ensure access to early intervention services.

(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 the existing administrative regulation: The amendments to this regulation remove obsolete language and procedures. Additional guidance is provided for clarity.

(b) The necessity of the amendment to this administrative regulation: Changes are necessary to fully comply with federal regulations found at 34 C.F.R. 303 and so that regulation reflects current practice and program reorganization.

(c) How the amendment conforms to the content of the authorizing statute: 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 provide guidance to the POE in matters related to child find or public awareness activities. Federal regulations require that all potentially eligible children be referred to the early intervention system as soon as possible. The enhanced list of those identified as a primary referral source will ensure compliance with this part of federal regulation. The changes to this regulation will also enhance the role of service coordinator to fully comply with federal regulation. The service coordinator is the leader of the individualized family service plan team and the updates to this regulation will elevate their role as team leader.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by the administrative regulation: Approximately 1,500 early intervention providers, including POE staff, will be affected by these regulations. Over 6,000 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 primary referral sources, early intervention providers, including service coordinators and POE staff, 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): The revisions to this administrative regulation do not cost the entities affected by the amended regulations any additional dollars.

(c) As a result of the compliance, what benefits will accrue to the entities identified in question (3): The amended regulations will help to identify children potentially eligible for early intervention services, and will benefit early intervention providers, including service coordinators by providing needed clarity so that they are more effective in their roles within the system.

(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 continuing 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 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 any 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 Point of Entry offices, approx. 1,500 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, 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 revenue generated by this administrative regulation during 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 expenditures to implement this administrative regulation 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: This administrative regulation will have an estimated $1-2 million savings to the program.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 34 C.F.R. 303 outlines the states requirements for implementing early intervention services. This amendment ensures full compliance with the provisions under that part.

2. State compliance standards.KRS 200.650 to 200.676 charges the Cabinet for Health and Family Services, Department for Public Health to implement early intervention services and comply fully with federal statutes and regulations.

3. Minimum or uniform standards contained in the federal mandate. By revising this administrative regulation Kentucky will be in full compliance under this part of the federal statute.

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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Maternal and Child Health
(Amendment)

902 KAR 30:120. Evaluation and eligibility.

RELATES TO: KRS 200.654, 200.668, 211.647, 216.2970, 34 C.F.R. 303.11, 303.321[~~303.300~~], 303.322, 303.421, 20 U.S.C. 1434

STATUTORY AUTHORITY: KRS 194A.030(7), 194A.050, 200.660(7), 34 C.F.R. 303.321[~~303.322~~], 20 U.S.C. 1434

NECESSITY, FUNCTION, AND CONFORMITY: KRS 200.660 requires the Cabinet for Health and Family Services to administer funds appropriated to implement the provisions of KRS 200.650 to 200.676, to enter into contracts with service providers, and to promulgate administrative regulations. This administrative regulation establishes the evaluation, eligibility, and redetermination of eligibility requirements for First Steps, Kentucky's Early Intervention Program.

Section 1. Initial Eligibility. (1) Initial eligibility shall be determined by:

(a) Administering at least one (1) evaluation instrument designed to confirm the presence of a significant developmental delay;

(b) Gathering information about the child's developmental history through parent interview;

(c) Identifying the child's level of functioning in each developmental area;

(d) Gathering information from other sources, such as childcare workers; and

(e) Reviewing all available medical and educational records.

(2) A child shall be eligible for First Steps service if the child:

(a) Is age birth up to three (3) years;

(b) Is a resident of Kentucky or homeless within the boundaries of the state at the time of referral and resides in Kentucky while receiving early intervention services; and

(c) 1. Has a documented established risk condition that has a high probability of resulting in developmental delay; or

2. Is determined to have a significant developmental delay based on the evaluation and assessment process.[~~(2) A determination of initial eligibility, assessments, and the initial IFSP team meeting shall occur within forty-five (45) calendar days after a point of entry receives an initial referral for a child who meets the requirements established in subsection (1) of this section.~~]

(3) Eligibility by established risk conditions:

(a) In accordance with KRS 200.654(10)(b), a child meeting the criteria established in subsection (1)(a) and (b) of this section with a suspected established risk condition shall be eligible once the diagnosis is confirmed by a physician. The established risk condition shall be documented in the child's record through the First Steps on-line data management system[~~and documented in the medical records provided to the First Steps Program~~].

(b) A list of approved established risk diagnoses shall be maintained by the First Steps Program and made available in policies and procedures.

1. A child with an established risk shall have a five (5) area assessment, assessing the five (5) areas listed in subsection (4)(a) of this section, completed by a developmental evaluator using a cabinet-approved, criterion referenced assessment instrument in lieu of a norm-referenced[~~primary level~~] evaluation, in accordance with 902 KAR 30:130.

2. If the established risk condition relates to hearing loss, the five (5) area assessment shall be:

a.[~~be~~] Performed by a speech therapist or a teacher of the deaf and hard of hearing; and

b. Authorized as a discipline specific assessment[~~who is approved as a developmental evaluator~~].

(4) Eligibility by developmental delay:

(a) A child meeting the criteria established in subsection (2)[~~(1)~~](a) and (b) of this section shall be eligible for First Steps services if the child is determined to have fallen significantly behind in development, based on the evaluation and assessment process, in one (1) or more of the following domains of development:

1. Total cognitive development;

2. Total communication area through speech and language development, which shall include expressive and receptive language;

3. Total physical development including motor development, vision, hearing, and general health status;

4. Total social and emotional development; or

5. Total adaptive skills development.

(b) Evidence of falling significantly behind in developmental norms shall be determined on a norm-referenced test by the child's score that is:

1. Two (2) standard deviations below the mean in one (1) skill area; or

2. At least one and one-half (1 1/2) standard deviations below the mean in two (2) skill areas.

(c)1. If a norm-referenced test reveals a delay in one (1) of the five (5) skill areas but does not meet the eligibility criteria required by paragraph (b) of this subsection, a more in-depth standardized test in that area of development may be administered if the following is evident:

a. The initial[~~primary level~~] evaluator and a parent or guardian have a concern or suspect that the child's delay is greater than the testing revealed;

b. A different norm-referenced test tool reveals a standardized score which would meet eligibility criteria; and

c. There is one (1) area of development that is of concern.

2. The results of the alternate testing required by subparagraph 1. of this paragraph shall determine the child's eligibility if the standardized scores indicate a delay of at least[~~greater than~~] two (2) standard deviations.

(5) Eligibility by professional judgment. A child may be determined eligible by informed clinical opinion by the following multidisciplinary evaluation teams of professionals:

(a) An approved neonatal follow-up program team, as described in 902 KAR 30:150, Section 2(3)(e);

(b) An approved intensive level evaluation team, as described in 902 KAR 30:150, Section 2(3)(d); or

(c) The designated record review team, if reviewing for eligibility.

[~~(6) To be an approved neonatal follow-up program team, a university-based program shall:~~

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

~~(b) Contract with the cabinet to conduct neuro-developmental follow-up of high risk infants.~~

~~(7) To be an approved intensive level evaluation team, two (2) or more professionals who meet the criteria established in Section 2(9) of this administrative regulation shall:~~

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

~~(b) Contract with the cabinet to conduct intensive level evaluations.~~]

Section 2. Initial Child Evaluation. (1) Prior to the administration of an evaluation instrument, the child's vision and hearing status shall be determined through screening or evaluation.

(2) A child referred to the First Steps Program who meets the criteria established in Section 1(2)[~~(1)~~](a) and (b) of this administrative regulation shall receive an initial evaluation to determine eligibility if:

(a) There is a suspected developmental delay as confirmed by the cabinet-approved screening protocol; [~~and~~]

(b) The child does not have an established risk diagnosis; and

(c) The parent requests and consents to an evaluation.

(3)[~~(2)~~] For a child without an established risk diagnosis, an initial[~~the primary level~~] evaluation shall be used to:

(a) Determine eligibility;

(b) Determine developmental status;

(c) Establish the baselines for progress monitoring; and

(d) Make recommendations to [~~for~~] the Individual Family Service Plan (IFSP) team[~~outcomes~~].

(4) For a child with an established risk diagnosis, a criterion referenced assessment shall be completed to:

(a) Determine developmental status;

(b) Establish the baseline for progress monitoring; and

(c) Make recommendations to the Individual Family Service Plan (IFSP) team.

(5)[(3)] (a) Initial[Primary level] evaluations shall include the five (5) developmental areas identified in Section 1(4)(a) of this administrative regulation using norm-referenced standardized instruments that provide a standard deviation score in the total domain for the five (5) areas and shall include a cabinet-approved criterion referenced assessment instrument, in accordance with 902 KAR 30:130.

(b) The initial[primary level] evaluation shall include:

1. A medical component completed by a physician or nurse practitioner that includes a recent complete history and physical examination and other medical information[:

a. History and physical examination;

b. Hearing and vision screening; and

c. Recent medical evaluation in accordance with the timelines established in subsection (5) of this section]; and

2. A developmental component completed by a cabinet-approved initial[primary level] evaluator, in accordance with 902 KAR 30:150, that includes:

a. A review of pertinent health and medical information; and

b. Completion of each appropriate instrument needed to determine the child's unique strengths and needs[; and

c. A recommendation of eligibility].

(c)[Results of the evaluation shall be explained to the family.

(d)] An evaluation report shall be entered into the First Steps online data management system[written]:

1. Within five (5) working[ten (10) calendar] days of the completion of the evaluation; and

2. In clear, concise language that is easily understood by the family.

(6)[(4)] Child records of evaluations transferred from a developmental evaluator outside the Kentucky Early Intervention System shall be reviewed by the Point of Entry staff and shall be used for eligibility determination if:

(a) The records meet evaluation timelines established in subsection (7)[(5)] of this section; and

(b) The records contain the developmental evaluation information required by subsection (5)(b)[(3)(b)] of this section.

(7)[(5)] If there is a recent medical or developmental evaluation available, as required by subsection (5)(b)[(3)(b)] of this section, it shall be used to determine eligibility if the evaluation was performed within:

(a) Three (3) months prior to referral to First Steps, for a child under twelve (12) months of age; or

(b) Six (6) months prior to referral to First Steps, for a child between twelve (12) months of age and three (3) years of age.

(8)[(6)](a) A child referred to the First Steps program who was born at less than thirty-seven (37) weeks gestational age shall be evaluated and assessed using an adjusted gestational age to correct for prematurity, unless the child is twenty-four (24) months of age or older at the time of the referral.

(b) For a child who is less than six (6) months corrected age, the initial[primary] evaluation shall be done by an approved intensive level evaluation team,[or] an approved neonatal follow-up program team, or an approved district child evaluation specialist in accordance with Section 1(5) of this administrative regulation.

(9)[(7)] If the child does not have an established risk diagnosis and is determined not eligible, the POE staff shall:

(a) Provide a First Steps Notice of Action (FS-9) in accordance with 34 C.F.R. 303.421; and

(b) Discuss available community resources, such as Medicaid, EPSDT, the Department for Public Health's and the Commission for Children with Special Health Care Need's (CCSHCN's) Title V programs, and other community programs[third-party payors].

(10)[(8)] A review of the child's First Steps record by the record review team shall be the second level in the First Steps evaluation system that shall be utilized to determine eligibility for cases which are complex or have contradictory information from testing.

(a) Upon obtaining a written consent by the parent or guardian, a service coordinator shall submit a child's record to the Department for Public Health or the designee for a record review if:

1. The child does not meet eligibility guidelines at the initial evaluation[primary level];

2. The initial[primary level] evaluator and a parent or guardian have concerns that the child is developing atypically; and

3. A determination of eligibility based on professional judgment is needed.

(b) Upon receiving a referral, a record review team shall conduct a record review and issue findings within ten (10) calendar days of receipt of the request.[(9) If the record review team requests an intensive level clinical evaluation, this shall be conducted by a team of early intervention professionals approved by the Part C Coordinator that shall include the following:

(a)1. A board certified medical professional with expertise in early childhood development;

2. A board certified developmental pediatrician;

3. A pediatrician who has training and experience in the area of early childhood development;

4. A board certified pediatric psychiatrist; or

5. A board certified pediatric neurologist; and

(b) One (1) or more developmental professionals identified in 902 KAR 30:150, Section 2(1)(a)-(s).]

Section 3. Annual Redetermination of Eligibility. (1) A redetermination of eligibility shall not be used to address concerns that are medical in nature.

(2) A child shall have continuing program eligibility for First Steps services if:

(a) The child is:

1. Under three (3) years old; and

2. A resident of Kentucky or homeless within the boundaries of the state; and

(b) The result of the most recent[semi-annual] progress review, including the annual five (5) area assessment, demonstrates:

1. A significant delay[An ongoing delay or failure to attain an expected level of development] in at least one (1) or more developmental areas; and

2. Continued First Steps services are required in order to support continuing developmental progress[by consensus of the IFSP team].

(3) Based on the results of the redetermination of eligibility, the IFSP team shall:

(a) Continue with the same outcomes and services;

(b) Continue with modified outcomes and services; or

(c) Transition the child from First Steps services.

(4) Redetermination of eligibility shall occur at least annually.

(a) The annual redetermination shall be part of the child's ongoing assessment and shall include an assessment in all five (5) areas by the Primary Service Provider (PSP) using a cabinet-approved criterion referenced instrument, in accordance with 902 KAR 30:130.

(b) If a person directly involved in conducting the evaluation and assessments is unable to attend an IFSP meeting, arrangements shall be made for that person's involvement by other means including participating in a telephone conference call, having a representative attend the meeting, or making[pertinent] records and reports available at the meeting.

Section 4. Determination of Child's Hearing Status. (1) If the referral is for a child who has a diagnosis of significant hearing loss, as specified by KRS 200.654(10)(b), the child shall be considered to have an established risk diagnosis and be eligible for First Steps services and the referral process shall continue.

(2) If the referral is for a child who is suspected of having a hearing loss, with no verification of degree of loss or diagnosis, and who is suspected of having developmental delays, the POE staff shall initiate the evaluation for First Steps, which shall include an audiological evaluation at an approved Infant Audiological Assessment and Diagnostic Center as specified by KRS 211.647 and 216.2970.

Section 5. Incorporation by Reference. (1) "First Steps Notice of Action (FS-9)", September 2012[The Early, Periodic, Screening,

~~Diagnostic and Treatment (EPSDT) Periodicity Schedule", August 2003~~] edition, is incorporated by reference.

(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: May 14, 2013

FILED WITH LRC: May 15, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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 provides requirements to establish a child's initial eligibility and the annual redetermination of eligibility for the Kentucky Early Intervention System. The requirements for child evaluation are included in this regulation.

(b) The necessity of this administrative regulation:
States must establish the specific detail for eligibility to receive early intervention services. While federal statute and regulation describe the mandatory populations of infants and toddlers to be served under Part C of the Individuals with Disabilities Education Improvement Act (PL 108-446), states set the specific procedures and criteria for eligibility.

(c) How this administrative regulation conforms to the content of the authorizing statute: KRS 200.650-200.676 requires the state to develop and implement a comprehensive, statewide early intervention system that complies with federal statute and regulation. KRS 200.652 (2) specifically requires the state to provide assistance and support to the family of an infant or toddler with a disability.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation will ensure that children who are eligible for early intervention service are appropriately identified. It also provides for the requirement for continued eligibility for early intervention services.

(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 provides specific guidance for evaluation and assessment, reflecting current program structure and best practices in the field of early intervention. It also removes obsolete and redundant language. Required federal regulatory language is also added to the administrative regulation. The listing of eligible medical conditions is updated. Criteria for eligibility by developmental delay is unchanged.

(b) The necessity of the amendment to this administrative regulation: The amendments are necessary to reduce costs for unnecessary evaluations and assessments and to specify procedures for federal requirements for reporting the entry and exit status of all children served by Part C of Pub.L. 108-446 (Federal requirement is found at 34 C.F.R. 303.721).

(c) How the amendment conforms to the content of the authorizing statute: 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 statute: The changes to the requirements for evaluation and assessment will allow the state regulations to align with federal regulations.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by the administrative regulation: Approximately 200 early intervention providers, including Point of Entry staff, will be affected by these regulations. Over 6,000 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): The Kentucky Early Intervention System currently costs approximately $40 million. The revisions to this administrative regulation will not cost the affected entities any additional dollars. Changes to evaluation and assessment represent an elimination of unnecessary and duplicative testing, resulting in efficiencies to the system as a whole.

(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 coordinator 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.

(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 funds (12 percent) and 88 percent state general funds will be used to implement this administrative regulation. No state match is required.

(7) Provide an assessment of whether an increase in fees of 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 any 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 fifteen (15) local Point of Entry, approx.

1,500 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. 1434, 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 revenue generated by this administrative regulation during 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 expenditures to implement this administrative regulation 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: There is no fiscal impact on local or state government for this administrative regulation.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 34 C.F.R. 303.310 through 303.322 outlines the states responsibilities in indentifying, evaluating and assessing children potentially eligible to receive early intervention services. This amendment ensures full compliance with the provisions under that part.

2. State compliance standards.KRS 200.650 charges the Cabinet for Health and Family Services, Department for Public Health to comply with all federal statutes and regulations.

3. Minimum or uniform standards contained in the federal mandate. By revising this administrative regulation to differentiate the process for initial eligibility (and the redetermination of eligibility Kentucky has streamlined the evaluation and assessment process.

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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Maternal and Child Health
(Amendment)

902 KAR 30:130. Assessment, service planning, and assistive technology.

RELATES TO: KRS 200.660(6), 200.664, 34 C.F.R. 303.321[~~303.322~~], 303.340-303.346, 20 U.S.C. 1435, 1436, 1437

STATUTORY AUTHORITY: KRS 194A.030(7), 194A.050, 200.660(8),[~~34 C.F.R. 303.500,~~] 20 U.S.C. 1436

NECESSITY, FUNCTION, AND CONFORMITY: KRS 200.660 requires the Cabinet for Health and Family Services to administer funds appropriated to implement the provisions of KRS 200.650 to 200.676, to enter into contracts with service providers, and to promulgate administrative regulations. This administrative regulation establishes the requirements for assessment, the Individualized Family Service Plans used in First Steps, and assistive technology.

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 family's child~~].

(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

3. Behavioral checklist and inventories.

(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)[~~(3)~~] 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[~~(4) 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)[~~(5)~~] 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 com-

parison 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

(d) 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~~

~~(e) 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, in accordance with 902 KAR 30:130, shall be submitted electronically to the Kentucky Early Childhood Data System within five (5) working[~~ten (10) calendar~~] days of the completion of the assessment.

(9)[~~(7)~~](a) 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 (5) working [~~ten (10) 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)~~](a) An assessment provided as a general practice of a discipline, not due to the child or family's needs, shall be considered early intervention, not an assessment.

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

(11) Five (5) working[~~(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[~~to the primary service coordinator and~~] family.

(12)[~~(10)~~](a) Within thirty (30)[~~120~~] 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, in accordance with 902 KAR 30:130.

(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)[~~120~~] 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) working 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) 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)1. A statement of the measurable results or measurable outcomes expected to be achieved for the child, including preliteracy and language skills as developmentally appropriate for the child, which shall:

a. Be functionally stated;

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

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

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

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

2. The criteria, procedures, and time lines used to determine the degree to which progress toward achieving the outcomes is being made; and

3. A statement indicating whether modifications or revision of the outcomes or services are necessary;

(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 or activity; 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 and which:

1. Are stated in length, frequency, intensity, duration, location and method of delivering services; and

2. Include payment arrangements;

(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 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)1. Other services that the child needs that are not early intervention services, such as medical services or housing for the family; and

2. Identification of 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;

(k) The name of:

1. The service coordinator representing the child's or family's needs who shall be responsible for the implementation of the IFSP and coordination with other agencies and person in accordance with 902 KAR 30:110, Section 2; and

2. The primary service provider;

(l) 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; and

3. Agrees that it is a necessary service; and

(b) The service is not covered by another payor source[~~(1) 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 Assurances - 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;~~

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

~~(f) A statement of the major outcomes expected to be achieved 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 expanded current and possible future environments;~~

~~(g) The specific First Step 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 exception 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. 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 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 projected dates for initiation of the services, and the anticipated length, duration, and frequency 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;~~

~~(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 returned 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.~~

~~(9) 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[~~assess~~] 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.

Section 5[4]. Incorporation by Reference.

(1) "Individualized Family Service Plan", September 2012[~~December 2008~~], is incorporated by reference.

(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: May 14, 2013

FILED WITH LRC: May 15, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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

(1) Provide a brief summary of 902 KAR 30:130:

(a) What this administrative regulation does: This administrative regulation outlines the requirements for assessment, service planning through the development of an individualized family service plan and assistive technology within the Kentucky Early Intervention System.

(b) The necessity of this administrative regulation: This regulation is necessary to provide guidance to service coordinators, primary level evaluation providers, intensive level evaluation teams and other service providers on child assessments, service planning and assistive technology. Assessment 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 supervise 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 administrative regulation: Approximately 1,500 early intervention providers, including Point of Entry staff, will be affected by these regulations. Over 6,000 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 and 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 fifteen (15) local Point of Entry, approx. 1,500 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 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.

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: 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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Maternal and Child Health
(Amendment)

902 KAR 30:150. Personnel qualifications.

RELATES TO: KRS 200.650-200.676[~~200.666, 20 U.S.C. 1431~~], 34 C.F.R. 303.31[~~22, 303.23(d)~~], 303.119[~~360, 303.361,~~] 303.121, 20 U.S.C. 1435(8), (9)[~~526~~]

STATUTORY AUTHORITY: KRS 194A.050, 200.660

NECESSITY, FUNCTION, AND CONFORMITY: KRS 200.660 requires the Cabinet for Health and Family Services to administer all funds appropriated to implement provisions of KRS 200.650 to 200.676[~~20.676~~], to enter into contracts with service providers, and to promulgate administrative regulations. This administrative regulation establishes the provider qualifications for participation in First Steps, Kentucky's Early Intervention Program.

Section 1. Enrollment Process for Provider Participation. (1) The program shall enroll providers to carry out the early intervention services according to the provisions of KRS 200.650 to 200.676.

(2) The program shall contract only with an individual or agency who meets the qualifications established in Section 2 of this administrative regulation.

(3) The program shall reserve the right to contract or not contract with any potential provider or agency.

(4) Any provider or agency that wishes to participate as a provider in the First Steps program shall submit an application packet to the cabinet.

(a)[~~Submit an application packet to the cabinet.~~] The application packet for the individual provider shall include:

1. A copy of the provider's professional license, registration, or certificate; and

2. The Individual Provider Application (RF 6A(I)).[~~A completed Provider Enrollment Form; and~~

~~3. A signed First Steps Provider Code of Ethical Conduct;~~]

(b) The application packet for the agency shall include:

1. A copy of each provider's professional license, registration, or certificate; and

2. The Agency Application (RF 6A(A)).

(c) All potential providers shall:

1.[~~(b)~~] Have a background check performed by the Administrative Office of the Courts, the Division of Protection and Permanency, and the Sex Offender Registry, with those agencies submitting the results of each background check directly to the cabinet;

2.[~~(c)~~] Agree to provide service within the individual's or agency's scope of practice and in accordance with state and federal regulations and laws relating to First Steps; and

3.[~~(d)~~] Be enrolled as a participating provider prior to being eligible to receive reimbursement in accordance with federal and state laws.

(5) The application shall not be considered complete and shall not be processed until all information and any subsequent documentation requested by the program is provided.

(6) The program shall make an enrollment determination within ninety (90) calendar days of receipt of the information required by subsections (4) and (5) of this section.

(7) If the applicant is approved for enrollment, the Service Provider Agreement shall be executed and the provider shall be issued a contract number that shall be used by the provider solely for identification purposes.

(8) A provider's participation shall begin and end on the dates specified in the executed Service Provider Agreement.

(9) If an agency is the enrolled provider, the agency shall be responsible for ensuring that all staff from that agency providing First Steps services meet the First Steps personnel qualifications.

(10) Provider enrollment shall be renewed every even-numbered year. An individual or agency wishing to renew the[~~a~~] Service Provider Agreement shall submit the documentation required by subsections (4) and (5) of this section prior to the end date specified in the Service Provider Agreement.

(11) If a provider agency is enrolling to provide group services, the agency shall submit:

(a) A copy of a valid child care licensure that meets the requirements stated in 922 KAR 2:090; or

(b) Approval as a contractor for group instruction through the Kentucky Department of Education.

Section 2. Personnel Qualifications. (1) Minimum qualifications for professionals or disciplines providing services in First Steps shall be as established in this subsection.

(a) An audiologist shall have:

1. A master's degree; and

2. A license from the Kentucky Board of Speech-Language Pathology and Audiology.

(b) A licensed marriage and family therapist shall have:

1. A master's degree; and

2. A license from the Kentucky Board of Licensure of Marriage and Family Therapists.

(c) A developmental interventionist shall have:

1. A bachelor's degree; and

2.[~~a.~~] An interdisciplinary early childhood education (IECE) certificate by the Kentucky Education Professional Standards Board, Division of Certification, or be able to obtain a probationary or emergency IECE certificate issued by the Educational Professional Standards Board[~~; or b. A valid out-of-state certificate for the teacher of children ages birth to three (3) years with disabilities~~].

(d) A nurse shall have:

1. An associate degree or diploma from a registered program; and

2. A license from the Kentucky Board of Nursing.

(e)[~~A nutritionist shall have:~~

~~1. A master's degree; and~~

~~2. A certificate from the Kentucky Board of Licensure and Certification for Dietitians and Nutritionists.(f)~~] A dietitian shall have:

1. A bachelor's degree; and

2. A license from the Kentucky Board of Licensure and Certification for Dietitians and Nutritionists.

(f)[~~(g)~~] An occupational therapist shall have:

1. A bachelor's degree; and

2. A license from the Kentucky Board of Licensure for Occupational Therapy.

(g)[~~(h)~~] An orientation and mobility (O and M) specialist shall have[~~in accordance with the Division of Exceptional Children Services, Kentucky Department of Education~~] a bachelor's degree in Special Education with emphasis on visual impairment and O and M, in accordance with the Division of Exceptional Children Services, Kentucky Department of Education.

(h)[~~(i)~~] A physician shall have:

1. A doctor of medicine degree or doctor of osteopathy degree; and

2. A license from the Kentucky Board of Medical Licensure.

(i)[~~(j)~~] A physical therapist shall have:

1. A bachelor's degree; and

2. A license from the Kentucky Board of Physical Therapy.

(j)[~~(k)~~] A licensed psychologist shall have:

1. A doctoral degree; and

2. A license from the Kentucky Board of Examiners of Psychology.

(k)[~~(l)~~] A certified psychologist with autonomous functioning, a licensed psychological practitioner, a certified psychologist or licensed psychological associate shall have:

1. A master's degree; and

2. A license or a certificate from the Kentucky Board of Examiners of Psychology.

(l)[~~(m)~~] A social worker shall have:

1. A bachelor's degree; and

2. A license from the Kentucky Board of Social Work.

(m)[~~(n)~~] A speech-language pathologist shall have:

1. A master's degree; and

2.a. A license from the Kentucky Board of Speech-Language Pathology and Audiology; or

b. A temporary license from the Kentucky Board of Speech-Language Pathology and Audiology and be under the supervision of a currently-enrolled First Steps speech-language pathologist.

(n)[~~(o)~~] A teacher of children who are deaf and hard of hearing shall have:

1. A bachelor's degree; and

2. A certificate for teaching the[~~hard of hearing, deaf, or~~] hearing impaired,[~~or a certificate for teaching the hearing impaired,~~] grades P-12,[~~K-12~~] issued by the Kentucky Education Professional Standards Board, Division of Certification.

(o)[~~(p)~~] A teacher of the visually impaired shall have:

1. A bachelor's degree; and

2. A certificate for teaching [~~of~~] the visually impaired, grades P-12,[~~or a certificate for teaching the partially seeing, blind, or visually impaired, K-12~~] issued by the Kentucky Education Professional Standards Board, Division of Certification.

(p)[~~(q)~~] A licensed professional clinical counselor shall have:

1. A master's degree; and

2. A license from the Kentucky Board of Licensed Professional Counselors.

(q)[~~(r)~~] An optometrist shall have:

1. A degree from an accredited school or college of optometry; and

2. A license from the Kentucky Board of Optometric Examiners.

(r)[~~(s)~~] An ophthalmologist shall have:

1. A doctor of medicine degree or doctor of osteopathy degree;

2. A license from the Kentucky Board of Medical Licensure; and

3. Certification from the American Board of Ophthalmology.

(2) The minimum qualification for paraprofessionals providing services in First Steps shall be as established in this subsection.

(a)[~~A developmental associate shall:~~

~~1. Have an associate degree in the area of interdisciplinary early childhood education (IECE); and~~

~~2. Be directly supervised by a developmental interventionist.~~ ~~(b)~~] An occupational therapy assistant shall have:

1. An associate's degree in occupational therapy; and

2. A license from the Kentucky Board of Licensure for Occupational Therapy.

(b)[~~(c)~~] A physical therapist's assistant shall have:

1. An associate degree in physical therapy assistance; and

2. A license from the Kentucky Board of Physical Therapy.

[~~(d) A licensed practical nurse shall have:~~

~~1. A high school diploma or a GED;~~

~~2. Completed a state approved LPN education program; and~~

~~3. A license from the Kentucky Board of Nursing.~~]

(3) The minimum qualifications for recognized service positions providing services in First Steps shall be as established in this subsection.

(a) A service coordinator shall:

1. Be employed by the point of entry;

2. Meet the minimum highest entry-level requirement for one (1) of the professions identified in subsection (1)(a)-(r) of this section[~~delineated in this administrative regulation~~]; or

3.[~~2.~~] Have a bachelor's degree and the equivalency of two (2) years of[~~years'~~] experience in working with young children ages birth through five (5) years, or have a bachelor's degree and two (2) years of[~~years'~~] experience working with families with young children ages birth through five (5) years, in a position in which the following skills and competencies have been demonstrated:

a. Communication skills in interviewing, negotiating and mediating, and providing informal support;

b. Problem-solving by finding and utilizing services and resources, resolving conflicts, integrating services using formal and informal channels, and enabling families to use problem-solving;

c. Organization by maintaining accurate data collection and resource information, exhibiting flexibility in scheduling, and developing plans; and

d. Collaboration and leadership through developing relationships with families, enabling families to develop their decision-making skills, and establishing collaborative relationships with service providers.

(b) A district child evaluation specialist shall:

1. Be employed by the point of entry to conduct screening, evaluations, and assessments, and provide consultation to service coordinators and primary level evaluators;

2. Meet the minimum highest entry-level requirements for one (1) of the professions identified in subsection (1)(a)-(r) of this section;

3. Have two (2) years of experience working directly with young children birth through two (2) years of age, including children with disabilities or atypical development;

4. Have one (1) year of experience in using standardized instruments and procedures to evaluate infants and toddlers birth through two (2) years of age, completed as part of formal training or in supervised practice; and

5. Be approved by the cabinet in accordance with KRS 200.666(1).

(c) An initial[~~A primary level~~] evaluator shall:

1. Meet the minimum highest entry-level requirements for one (1) of the professions delineated in this administrative regulation;

2. Have two (2) years of experience working directly with young children birth through two (2) years of age, including children with disabilities or atypical development;

3. Have one (1) year of experience in using standardized instruments and procedures to evaluate infants and toddlers birth through two (2) years of age, completed as part of formal training or in supervised practice; and

4. Be approved by the cabinet in accordance with KRS 200.666(1).

(d) An intensive level evaluation team shall be approved by the Part C Coordinator and shall include:

1. a. A board certified medical professional with expertise in early childhood development;

b. A board certified developmental pediatrician;

c. A pediatrician who has training and experience in the area of early childhood development;

d. A board certified pediatric psychiatrist; or

e. A board certified pediatric neurologist; and

2. One (1) or more developmental professionals identified in subsection (1)(a)-(r) of this section.

(e) An approved neonatal follow-up program team shall be a university-based program that has:

1. Submitted to the cabinet the credentials and documentation of experience in conducting assessments for the birth to three (3) age population for each proposed team member; and

2. Contracted with the cabinet to conduct neuro-developmental follow-up of high risk infants.

(f)[~~(c)~~] An assistive technology specialists shall:

1.a.(i) Meet the minimum highest entry-level requirements for one (1) of the professions delineated in this administrative regulation; and

(ii) Have extensive knowledge, training, and experience in the field of assistive technologies for infants and toddlers with disabilities; or

b.(i) Meet the qualifications established in clause a.(ii) of this paragraph; and

(ii) Be employed by an agency that currently provides assistive

technology service in First Steps; and

2. Be approved by the cabinet in accordance with KRS 200.666(1).

(g) To be an approved assistive technology review team, an assistive technology center shall:

1. 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

2. Contract with the cabinet to conduct reviews of requests for assistive technology devices in accordance with 902 KAR 30:130, Section 4.

(h)[~~(d)~~] A respite provider shall:

1. Meet all license, administrative regulations, and other requirements applicable to the setting in which respite is provided; and

2. Be approved by the individualized family service planning team.

(i) A sign language and cued language specialist shall:

1. Meet the qualifications established in 201 KAR 39:030, Section 3(1)(a), (b), (c), (e), (m) or (2)(a), (b), (c); and

2. Be approved by the cabinet in accordance with KRS 200.666(1).

Section 3. Field Experiences - Intervention services implemented by a student. (1) With family consent, a student may provide early intervention services under the direct one-to-one supervision of a provider qualified in accordance with Sections 1 and 2 of this administrative regulation.

(2) A student who provides early intervention services shall complete and sign staff notes for each session in which the student facilitates or provides intervention.

(3) The approved First Steps provider shall also include a staff note for each session involving a student.

Section 4. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Form 6A(I), Individual Provider Application (New)", October 2012 edition[~~"Form 6, Provider Enrollment Form", April 2008 edition~~];

(b) "Form 6A(A) Agency Application (New)", October 2012 edition;

(c) "Form 6B(I) Individual Provider Application (Renewal)", January 2012 edition;

(d) "Form 6B(A) Agency Application (Renewal)", January 2012 edition;

(e) "First Steps Provider Code of Ethical Conduct"; January 2012[~~April 2010~~] edition; and

(f)[~~(c)~~] "Form 5A, Service Provider Agreement", January 2012[~~April 2010~~] edition.

(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: May 14, 2013

FILED WITH LRC: May 15, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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

(1) Provide a brief summary of 902 KAR 30:150:

(a) What this administration regulation does: This regulation outlines the process for provider enrollment with the Kentucky Early Intervention System program and defines the minimum qualifications for the professionals or disciplines that provide early intervention services.

(b) The necessity of this administrative regulation: 902 KAR 30:150 is necessary to define the professionals or disciplines that may provide early intervention services.

(c) How this administrative regulation conforms to the content of the authorizing statute: KRS 200.650 (6) requires the cabinet to comply with federal law as it pertains to services for infants and toddlers with disabilities and their families. KRS 200.666 requires the cabinet to monitor personnel standards for providers wishing to contract with Kentucky Early Intervention System.

(d) How this administrative regulation currently assists in the effective administration of the statutes: The regulation is needed to provide 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 the existing administrative regulation: The amendment to this regulation removes the allowance for a developmental interventionist to hold an out of state certificate and removes the discipline of nutritionist which has been removed from federal regulations. The qualifications for a district child evaluation specialist have been added to this amendment. The qualifications for an intensive level evaluation team and a neonatal follow up program team have been moved from 902 KAR 30:120 to this regulation. The requirements for the assistive technology monitoring committee were added to this regulation. The discipline for a sign language and cued speech language specialist has been added to comply with federal regulation.

(b) The necessity of the amendment to this administrative regulation: Because changes in the federal regulations eliminated nutritionist and added sign language and cued speech KEIS was required to update the state regulation to be in compliance with federal regulations. The other changes make this regulation more detailed and streamline the other regulations that were changed by moving the requirements for the intensive level evaluation team, neonatal follow up program team and assistive technology monitoring committee qualifications.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 200.650 (6) requires that the state be in compliance with federal law and KRS 200.652 (3) requires a statewide system of early intervention services. The amendments to the administrative regulations accomplish these two requirements.

(d) How the amendment will assist in the effective administration of the statutes: These amendments will help to assure compliance with federal statute and regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by the administrative regulation: Approximately 1,500 early intervention providers, including Point of Entry staff, will be affected by these 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: Regulated entities will continue to provide early intervention services as they currently practice. Profes-

sionals who practice the discipline of sign language and cued speech language will be able to enroll as First Steps providers. Those who are wishing to enroll as an intensive level evaluation team, a neonatal follow up program team, an assistive technology monitoring committee member or as a district child evaluation specialist will have to be approved by the state lead agency.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There are no additional costs to entities to comply with the amended regulations.

(c) As a result of the compliance, what benefits will accrue to the entities identified in question (3): Individuals who meet the early intervention provider qualifications are eligible to enroll as a provider for and be paid by the First Steps system.

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

(a) Initially: There are no costs to implement the amendment to this regulation.

(b) On a continuing basis: There are no costs to implement the amendment to 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, state general funds, and Medicaid funds are used to support the early intervention system.

(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 amended administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: No, this administrative regulation does not directly or indirectly increase any 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. Chapter 33, 34 C.F.R. Part 303, KRS 194A.050, KRS 200.652 and 200.666.

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 revenue generated by this administrative regulation during 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 expenditures to implement this administrative regulation 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:

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 34 C.F.R. 303.118 through 303.119 outline the requirements for a comprehensive system of personnel development (CSPD) and personnel standards. This amendment ensures full compliance with the provisions under that part.

2. State compliance standards KRS 200.666 charges the Cabinet for Health and Family Services, Department for Public Health to monitor personnel standards for service providers to ensure the qualified service providers necessary to carry out the provisions of KRS 200.650 to 200.676 are appropriately and adequately prepared and trained in order to comply with the requirements of federal law and regulations.

3. Minimum or uniform standards contained in the federal mandate. By revising this administrative regulation Kentucky is ensuring that all those interested in becoming early intervention providers and service coordinators meet the highest level of qualifications for their contracted discipline.

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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Maternal and Child Health
(Amendment)

902 KAR 30:160. Covered services.

RELATES TO: KRS 200.656, 34 C.F.R. 303.13, 303.421(c), 20 U.S.C. 1435[~~, 34 C.F.R. 303.12~~]

STATUTORY AUTHORITY: KRS 194A.030, 194A.050, 200.660

NECESSITY, FUNCTION, AND CONFORMITY: KRS 200.660 requires the Cabinet for Health and Family Services to administer all funds appropriated to implement provisions of KRS 200.650 to 200.676, to enter into contracts with service providers, and to promulgate administrative regulations. This administrative regulation establishes the provisions of covered services under First Steps, Kentucky's Early Intervention Program.

Section 1. Covered Services. (1) Services shall be covered if the services are included and authorized through parent signature on the Individualized Family Service Plan (IFSP) developed by an IFSP team which shall include, at a minimum, the family and two (2):

(a) Professionals as identified in 902 KAR 30:150, Section 2(1);

(b) Paraprofessionals as identified in 902 KAR 30:150, Section 2(2); or

(c) Service positions as identified in 902 KAR 30:150, Section 2(3).(2) Services covered shall include:

(a) Service coordination as provided in accordance with 902 KAR 30:110, Section 3[~~2~~], and this paragraph:

1. A child shall have only one (1) designated service coordinator at a given time;

2. Service coordination shall be provided by qualified professionals in accordance with 902 KAR 30:150, Section 2(1); and

3. Service coordination shall be provided under the limitations of 902 KAR 30:200, Sections 2(2)(a) and 2(3)(b);

(b) Initial[~~Primary~~] evaluation as provided in accordance with 902 KAR 30:120 and this paragraph. Initial[~~Primary~~] evaluation shall be:

1. Considered the first level of a two (2) tier system of evalua-

tion; and

2. Provided by qualified professionals in accordance with 902 KAR 30:150, Section 2(3)(c)[(b)];

(c) Intensive team evaluation as provided in accordance with 902 KAR 30:120, Section 1(4), and this paragraph. Intensive team evaluation shall be:

1. Considered the second level of a two (2) tier system of evaluation; and

2. Provided by qualified professionals in accordance with 902 KAR 30:120, Section 2(9);

(d) Assessment of the child as provided in accordance with 902 KAR 30:130, Section 1, and 902 KAR 30:200, Section 3(1);

(e) Early intervention.

1. Early intervention shall be provided in accordance with 34 C.F.R. 303.13(a) and (b).

2. Except as provided in subparagraph 3.[2.] of this paragraph, early intervention, which is face-to-face intervention with the child and caregivers within the context of the environment, shall include four (4)[three (3)] types of service:

a. Individual home or community service which shall include intervention provided by a First Steps qualified professional to an eligible child at the child's home or other natural setting in which children under three (3) years of age are typically found(including non-First Steps provider day care centers or family day care homes) under the limitations of 902 KAR 30:200, Section 3(2);

b. Individual office or center-based service which shall include intervention provided by First Steps qualified professionals to an eligible child at the professional's office or center site under the limitations of 902 KAR 30:200, Section 3(2);[or]

c. Group intervention which shall include the provision of early intervention services by First Steps qualified personnel in a group, with two (2) or more eligible children, at an early intervention professional's site, office, center, or other community-based setting where children under three (3) years of age are typically found.

(i) The group may also include children without disabilities as long as a three (3) to one (1) ratio of children to staff is maintained.

(ii) Group intervention shall be provided under the limitations of 902 KAR 30:200, Section 3(2)(b); or

d. Co-treatment which shall occur if more than one (1) provider is present and providing early intervention services at the same time. Each provider's service log shall document:

(i) Why this approach is being used;

(ii) The outcomes and activities;

(iii) Who is performing the activities; and

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

3.[2.] If early intervention services are provided by a psychologist, counselor, marriage and family therapist, or social worker, the child shall not be required to attend the intervention. The reason the child's presence is clinically contraindicated shall be documented in the service note.

4.[3.] Disciplines providing early intervention shall be qualified professionals in accordance with 902 KAR 30:150, Section 2(1), or qualified paraprofessionals in accordance with 902 KAR 30:150, Section 2(2), and shall include the following:

a. An audiologist;

b. A marriage and family therapist;

c. A developmental interventionist;

d.[A developmental associate;

e.] A nurse;

e. [f. An LPN;

g. A nutritionist;

h.] A dietician;

f.[i.] An occupational therapist;

g.[j.] An occupational therapy assistant;

h.[k.] An orientation and mobility specialist;

i.[l.] A physical therapist;

j.[m.] A physical therapist's assistant;

k.[n.] A licensed psychologist, a certified psychologist with autonomous functioning, a licensed psychological practitioner, certified psychologist, or licensed psychological associate;

l.[o.] A speech-language pathologist;

m.[p.] A licensed social worker;

n.[q.] A licensed professional clinical counselor (LPCC);

o.[r.] A teacher of the visually impaired;

p.[s.] A teacher of the deaf and hard of hearing;

q.[t.] A physician;

r.[u.] An optometrist;

s.[or v.] An ophthalmologist; or

t. A sign language and cued language specialist;

(f)[Integrated disciplines center-based service shall be provided by an agency that is approved by the Department for Public Health to be qualified to offer services:

1. By at least three (3) of the following disciplines working together in a group setting who qualify in accordance with 902 KAR 30:150, Section 2(1)(c), (g), (j), and (n):

a. Developmental interventionist;

b. Occupational therapist;

c. Physical therapist; or

d. Speech-language pathologist;

2. At least three (3) disciplines shall be scheduled and present, except in routine absences due to sickness or other conflicts;

3. The providers shall give evidence of transdisciplinary planning and practice;

4. If integrated discipline center-based service is in the IFSP, with the majority of the group make-up being children who need three (3) or more disciplines, except if approved by the Department for Public Health; and

5. Each child's record shall have a staff note from each discipline, except a staff note shall not be required from a discipline if the discipline is not identified in the IFSP as a needed service; (g)] Collateral service as provided in accordance with 902 KAR 30:200, Section 3(4);

(g)[(h)] Assistive technology in accordance with 902 KAR 30:001, Section 1(3), and 30:130, Section 4;

(h)[(i)] Respite which shall be a service provided to the family of an eligible child for the purpose of providing relief from the care of the child in order to strengthen the family's ability to attend to the child's developmental needs under the limitations of 902 KAR 30:200, Section 3(3);

(i)[(j)] Transportation and related cost which shall be the costs of travel that are necessary to enable an eligible child to receive early intervention services; and

(j)[(k)] Language access services for all families consistent with the provisions of the Individuals with Disabilities Education Improvement Act (IDEA), 34 C.F.R. 303.421(c)[303.403], that, at a minimum, assists the family in understanding the purpose of First Steps and the family's procedural safeguards during referral, eligibility determination activities, and IFSP meetings. 902 KAR 30:160 Kentucky Early Intervention Covered Services.

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

APPROVED BY AGENCY: May 14, 2013

FILED WITH LRC: May 15, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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

(1) Provide a brief summary of 902 KAR 30:160:

(a) What this administrative regulation does: This regulation describes the services that are provided and paid in the Kentucky Early Intervention system.

(b) The necessity of this administrative regulation: This regulation is necessary to eliminate confusion in the types of services provided and paid by the Kentucky Early Intervention System. The Kentucky Early Intervention System uses multiple funding streams to support the provision of services.

(c) How this administrative regulation conforms to the content of the authorizing statute: KRS 200.652 (5) requires the coordination of payment for early intervention services from federal, state, local and private insurance coverage, and the use of sliding fee scales.

(d) How this administrative regulation currently assists in the effective administration of the statutes: The regulation is needed to provide 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 the existing administrative regulation: The changes in this regulation remove redundant and obsolete language. Changes were also made to bring the state regulation into compliance with the federal regulations.

(b) The necessity of the amendment to this administrative regulation: The requirements and intent of the federal statute for state early intervention systems needed clarification. The amendments to this regulation mirror the changes made to the approved disciplines in 902 KAR 30:160.

(c) How the amendment conforms to the content of the authorizing statute: KRS 200.652 (3) and (5) require the state to implement a statewide, comprehensive, interagency system of early intervention and to facilitate payment from multiple funding streams.

(d) How the amendment will assist in the effective administration of the statute: These amendments will help to assure compliance with federal statute and regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by the administrative regulation: Approximately 1,500 early intervention providers will be affected by these 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: Regulated entities will continue to provide early intervention services as they currently practice.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There are no additional costs to entities to comply with the amended regulations.

(c) As a result of the compliance, what benefits will accrue to the entities identified in question (3): Early intervention providers will be eligible for payment of covered services and participation in First Steps.

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

(a) Initially: There are no costs to implement the amendment to this regulation.

(b) On a continuing basis: There are no costs to implement the amendment to 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, state general funds, and Medicaid funds are used to support the early intervention system.

(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 amended administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: No, this administrative regulation does not directly or indirectly increase any 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 fifteen (15) local Point of Entry, approx. 1,500 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, 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 revenue generated by this administrative regulation 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? There will be no revenue generated by this administrative regulation during 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 for the first year.

(d) How much will it cost to administer this program for subsequent years? There will be no expenditures to implement this administrative regulation 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: There is no fiscal impact on local or state government for this administrative regulation.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 34 C.F.R. 303.340 through 303.346 outlines the content if the Individual Family Service Plan (IFSP), including the content of the IFSP and responsibility and accountability. 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 to develop an Individual Family Service Plan the conforms to the federal requirements for the IFSP.

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

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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Maternal and Child Health
(Amendment)

902 KAR 30:180. Procedural safeguards.

RELATES TO: KRS 13B.080, 200.672, [~~20 U.S.C. 1439,~~] 34 C.F.R. 303.400-303.438, 20 U.S.C. 1439[~~to 303.460~~]

STATUTORY AUTHORITY: KRS 194A.050, 200.660

NECESSITY, FUNCTION, AND CONFORMITY: KRS 200.660 requires the Cabinet for Health and Family Services to administer all funds appropriated to implement provisions of KRS 200.650 to 200.676, to enter into contracts with service providers, and to promulgate administrative regulations. This administrative regulation establishes procedural safeguards for facilities participating in First Steps, Kentucky's Early Intervention System.

Section 1. Records.[~~Definitions.~~

~~(1) "Consent" means:~~

~~(a) The parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language or other mode of communication;~~

~~(b) The parent understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records (if any) that will be released and to whom; and~~

~~(c) The parent understands that the granting of consent is voluntary and may be revoked at any time.~~

~~(2) "Native language" means the language or mode of communication normally used by the parent of a child eligible for or participating in First Steps.~~

~~(3) "Personally identifiable" means that information includes:~~

~~(a) The name of the child, the child's parent, or other family member;~~

~~(b) The address of the child;~~

~~(c) A personal identifier, such as the child's or parent's Social Security Number; or~~

~~(d) A list of personal characteristics or other information that would make it possible to identify the child with reasonable certainty.~~

~~Section 2.~~] (1) In accordance with 34 C.F.R. 303.400 through 303.417[~~303.460~~], the parents of a child eligible for the Kentucky Early Intervention Program shall be afforded the opportunity to inspect,[~~and~~] review, and receive records relating to evaluations and assessments, eligibility determinations, the development and implementation of IFSPs, individual complaints dealing with the child, and any other records maintained by First Steps staff about the child and the child's family.

(2) The first requested copy of the early intervention record released to the parent or guardian shall be at no cost.

(3) A fee of ten (10) dollars shall be charged for each additional copy and shall not prevent the parent or guardian from exercising the right to inspect and review those records.

(4) An early intervention provider or agency shall inform parents when personally identifiable information collected, maintained, or used during the provision of early intervention services is no longer needed to provide services to the child.

Section 2. Parental notice and consent. (1)[~~(2)~~] Prior written notice.

(a) Prior written notice shall be given to the parents of an eligible child at least five (5) working[~~seven (7)~~] days before the Point of Entry (POE) staff or service provider proposes or refuses to initiate or change the identification, evaluation, or placement of the child, or the provision of appropriate early intervention services to the child and the child's family.

(b) The notice shall be in sufficient detail to inform the parents about:

1. The action that is being proposed or refused;

2. The reasons for taking the action;

3. All procedural safeguards that are available to the parent; and

4. The[~~complaint~~] procedures under 34 C.F.R. 303.430 303.434[~~303.510-303.512, including a description of how to file a complaint and the required timelines under those procedures~~].

(c) The written prior notice shall be:

1. Written in language understandable to the general public; and

2. Provided in the native language or other mode of communication of the parents, unless it is clearly not feasible to do so.

(d) If the native language or other mode of communication of the parent is not a written language, the POE staff, or designated service provider, shall take steps to ensure that:

1. The notice is translated orally or by other means to the parent in the parent's native language or other mode of communication;

2. The parent understands the notice; and

3. There is written evidence that the requirements of this paragraph have been met.

(2)[~~(e) If a parent is deaf or blind, or has no written language, the mode of communication shall be that normally used by the parent (which may include sign language, Braille, or oral communication).(3)~~] Parent consent.

(a) Written parental consent shall be obtained before:

1. Administering any screening procedures;

2. Conducting all evaluations and assessments[~~the initial evaluation and assessment~~] of a child;

3.[~~and 2.~~] Initiating the provision of early intervention services;

4. Billing private insurance; and

5. Disclosing personally identifiable information.

(b) If consent is not given for screening, evaluation, assessment, or early intervention services, the POE shall make reasonable efforts to ensure that the parent understands:

1. The nature of the evaluation and assessment or the services available; and

2. That the child will not receive the evaluation and assessment or services unless consent is given.

(3)[~~(5)~~] The parents of an eligible child may determine if they, their child, or other family members will accept or decline any early intervention service, and may decline a service after first accepting it, without jeopardizing other early intervention services.

Section 3. Representation of Children and Surrogate Parents. (1) Each POE shall ensure that the rights of an eligible child are protected if:

(a) A parent, as defined in 902 KAR 30:001, Section 1(28)[~~(21)~~], cannot be identified;

(b) The POE, after reasonable efforts, cannot discover the whereabouts of a parent; or

(c) The child is a ward of the state.

(2) If the child is a foster child and does not reside with the child's parents, the POE shall make reasonable efforts to obtain the informed consent of the parent for an initial evaluation. The POE shall not be required to obtain parental consent if:

(a) Despite reasonable efforts, the POE cannot discover the whereabouts of the parent;

(b) The rights of the parents have been terminated; or

(c) The rights of the parents to make educational decisions have been subrogated by a court and the consent for initial evaluation has been given by someone appointed by the judge to represent the child.

(3)(a) If more than one (1) party meets the definition of parent under 902 KAR 30:001, Section 1(28)[~~(21)~~], the biological or adoptive parent shall be presumed to be the parent unless the biological or adoptive parent does not have the legal authority to make educational decisions for the child.

(b) If there is a judicial order that identifies a specific person to act as the parent of a child or to make educational decisions on behalf of a child, the order shall prevail.

(4)(a) A POE shall determine if a child needs a surrogate parent and, if so, shall assign a surrogate parent to the child.

(b) The surrogate parent of the child shall have all the rights afforded parents under 34 C.F.R. Part 303 to make decisions about early intervention issues for a child.

(c) A POE shall ensure the rights of a child are protected by appointing a surrogate parent to make educational decisions for the child if:

1. An individual cannot be identified as a parent;

2. The POE, after reasonable efforts, cannot discover the whereabouts of the parents;

3. The child is a ward of the state; or

4. The child is an unaccompanied homeless child.

(5) The POE shall keep a record of the reasonable efforts made to discover the whereabouts of the parents, including:

(a) Detailed records of the telephone calls made or attempted and the results of those calls;

(b) Copies of correspondence sent to the parents and any responses received; and

(c) Detailed records of visits made to the parent's home or place of employment and the results of those visits.

(6) The POE shall have a procedure for selecting surrogates that is approved by the Department of Public Health. The department shall approve a procedure that is established to ensure that a surrogate:

(a) Is not an employee of the Kentucky Department for Public Health, the POE, or any other state agency that is involved in early intervention services or care of the child;

(b) Does not have any personal or professional interest that conflicts with the interests of the child; and

(c) Has knowledge and skills that ensure adequate representation of the child.

(7) A person who is otherwise qualified to be a surrogate parent shall not be considered an employee of the POE solely because he or she is paid by the POE to serve as a surrogate parent.

(8) If a child is an unaccompanied homeless child, appropriate staff of emergency shelters, transitional shelters, or street outreach programs may be appointed as temporary surrogate parents without regard to the criteria listed in subsection (6) of this section until a surrogate parent can be appointed that meets all the requirements of this section.

(9) The POE shall make reasonable efforts to ensure the assignment of a surrogate not more than thirty (30) calendar days after there is a determination by the Point of Entry that the child needs a surrogate.

(10) Responsibilities. A surrogate parent shall represent a child in all matters related to:

(a) The evaluation and assessment of the child;

(b) Development and implementation of the child's IFSPs, including annual evaluations and periodic reviews;

(c) The ongoing provision of early intervention services to the child; and

(d) Any other rights established under this administrative regulation.

Section 4. Mediation. (1) Each POE shall ensure that procedures are established and implemented to allow parties to disputes involving any matter concerning the identification, evaluation, placement of the child or the provision of appropriate early intervention services to resolve the disputes through a mediation process which, at a minimum, shall be available if a hearing is requested under 34 C.F.R. 303.431[~~303.420~~].

(2) The POE agency shall use the mediation system established by the Department for Public Health.

(a) Mediation shall be adopted as an option to resolve complaints.

(b) Mediation shall be voluntary and freely agreed to by both parties, and shall not deny or delay a parent's right to a due process hearing to be conducted at any time.

(c) Unless the parent of a child and the cabinet otherwise agree, the child shall continue to receive the early intervention services currently being provided during the interim of any proceeding involving a complaint. If the complaint involves the application for initial services, the child shall receive those services that are not in dispute.

(d) Mediators shall be trained in applicable state and federal law relating to the First Steps program.

(3) Time table for mediation.

(a) Within five (5) working days after a request for mediation is made to the department using a Mediation/Due Process Request Form, the appointment of a mediator shall be made.

(b) Either party may waive the mediation and, if waived, the parents shall be informed by the department within two (2) working days of this decision.

(c) Mediation shall be completed within thirty (30) working days of the receipt by the department of the request for mediation.

(d) At any time during the mediation process, a request for a due process hearing may be initiated.

(e) If the parties resolve a dispute through the mediation process, the parties shall execute a legally binding agreement that is signed by both the parent and a representative of the lead agency who has the authority to enter into an agreement.

(f) A copy of the legally binding agreement[~~written resolution~~] shall be mailed by the mediator to each party within five (5) working days following the mediation conference. A copy shall also be filed by the mediator with the department. The agreement[~~written resolution~~] shall specify in writing the agreement reached by the parties.

(4) A written mediation agreement[~~Mediation resolutions~~] shall not conflict with state and federal laws and shall be to the satisfaction of both parties. Satisfaction shall be indicated by the signature of both parties on the legally binding agreement[~~written resolution~~].

(5) Discussions that occur during the mediation process shall be confidential and shall not be used as evidence in any subsequent due process hearing or civil proceeding. The parties to the mediation process shall be required to sign a confidentiality pledge prior to the commencement of the process.

Section 5. Due Process Procedures for Parents and Children. (1)[~~(a)~~] An administrative hearing shall be conducted within fifteen (15) days of receipt of a request for hearing by an impartial hearing officer appointed by the secretary of the cabinet.

(2)[~~(b)~~] The hearing shall be conducted in accordance with the requirements of KRS Chapter 13B.080.

(3)[~~(c)~~] A recommended decision conforming in content to the requirements of KRS 13B.110 shall be forwarded to the family and the cabinet within ten (10) days of the administrative hearing.

(4)[~~(d)~~] All parties to the appeal shall have five (5) days to file written exceptions to the recommended decision.

(5)[~~(e)~~] A final decision on the recommendation shall be made no later than forty-five (45) days following receipt of the appeal.

(6)[~~(f)~~] Any parent involved in an administrative hearing may:

(a)[~~1.~~] Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to early intervention services for children eligible for the First Steps Program;

(b)[~~2.~~] Present evidence and confront, cross-examine, and compel the attendance of witnesses;

(c)[~~3.~~] Prohibit the introduction of any evidence at the proceeding that has not been disclosed to the parent at least five (5) days before the proceeding;

(d)[~~4.~~] Obtain a written or electronic verbatim transcription of the proceeding; and

(e)[~~5.~~] Obtain written findings of fact and decisions.

(7)[~~(g)~~] Any proceeding for implementing the complaint resolution process established in Section 4 of this administrative regulation shall be held at a time and place that is reasonably convenient to the parent.

(8)[~~(h)~~] Any party aggrieved by the findings and decision regarding an administrative hearing may bring a civil action in state or federal court under 20 U.S.C. 1439(a)(1).

(9)[~~(i)~~] During the pendency of any proceeding involving a hearing under this section, unless the POE and parents of a child otherwise agree, the child shall continue to receive the appropriate early intervention services currently being provided. If the complaint involves an application for initial early intervention services, the child shall receive those services that are not in dispute.

Section 6.[~~(2)~~] State Complaint Procedures. The procedures established in this section[~~subsection~~] shall apply to the Cabinet for Health and Family Services, Department for Public Health as to written complaints submitted pursuant to 34 C.F.R. 303.432-303.434[~~303.320 through 303.460~~].

(1) Any organization or individual may file a signed written complaint.[~~(a)~~] The complaint shall be submitted on a First Steps Complaint Form and shall include:

(a)[~~1.~~] A statement that the state lead agency, point of entry, or early intervention provider has violated a requirement of state or federal law;

(b)[~~and 2.~~] The facts on which the complaint is based; and

(c) The signature and contact information for the complainant.

(2) If the alleged violation is with respect to a specific child, the complaint shall include:

(a) The name and address of the residence of the child;

(b) The name of the early intervention provider serving the child;

(c) A description of the nature of the problem of the child, including facts related to the problem; and

(d) A proposed resolution of the problem to the extent known and available to the party at the time the complaint is filed.

(3)[~~(b)~~]The alleged violation shall have occurred not more than one (1) year before the date that the complaint is received by the Department for Public Health[~~unless a longer period is reasonable because:~~

~~1. The alleged violation continues for that child or other children; or~~

~~2. The complainant is requesting reimbursement or corrective action for a violation that occurred not more than three (3) years before the date on which the complaint is received by the Department for Public Health~~].

(4) The party filing the complaint shall forward a copy of the complaint to the point of entry or early intervention provider serving the child at the same time the party files the complaint with the state lead agency.

(5)[~~(c)~~] Within sixty (60) calendar days after a complaint is filed, the Department for Public Health shall:

(a)[~~1.~~] Carry out an independent on-site investigation, if the agency determines that an investigation is necessary;

(b)[~~2.~~] Give the complainant the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint;

(c) Provide the point of entry or early intervention provider an opportunity to respond to the complaint, including:

1. A proposal to resolve the complaint; and

2. An opportunity for a parent who has filed a complaint and the point of entry or early intervention provider to voluntarily engage in mediation, in accordance with Section 4 of this administrative regulation;

(d)[~~3.~~] Review all relevant information and make an independent determination as to whether the point of entry or early intervention provider[~~public agency~~] is violating a requirement of the Kentucky Early Intervention System;

(e)[~~4.~~] Issue a written decision to the complainant that addresses each allegation in the complaint and contains:

1.[~~a.~~] Findings of fact and conclusions; and

2.[~~b.~~] The reasons for the agency's final decision;

(f)[~~5.~~] Permit an extension of the sixty (60) day time limit only if exceptional circumstances exist with respect to a particular complaint; and

(g)[~~6.~~] Include procedures for effective implementation of the state lead agency's final decision, if needed, including:

1.[~~a.~~] Technical assistance activities;

2.[~~b.~~] Negotiations; and

3.[~~c.~~] Corrective actions to achieve compliance.

(6)[~~(d)~~] If a written complaint is received that is also the subject of a due process hearing or contains multiple issues, of which one or more are part of a due process hearing, the Department for Public Health shall set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. Any issue in the complaint that is not a part of the due process action shall be resolved within the sixty (60) calendar-day timeline using the complaint procedures established in this section.

(7)[~~(e)~~] If an issue is raised in a complaint filed under this section that has previously been decided in a due process hearing involving the same parties, the:

a.[~~The~~] Hearing decision shall be binding; and

b.[~~The~~] Agency shall inform the complainant of that effect.

(8)[~~(f)~~] A complaint alleging the state lead agency, point of entry, or early intervention[~~a public agency's or private service~~] provider's failure to implement a due process decision shall be resolved by the Department for Public Health.

Section 7[~~5~~]. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) First Steps Complaint Form, August 2012 edition[~~December 2010~~]; and

(b) Mediation/Due Process Request Form, May 2012 edition[~~November 2010~~].

(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:

FILED WITH LRC: May 14, 2013

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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

(1) Provide a brief summary of 902 KAR 30:180:

(a) What this administrative regulation does: This administrative regulation establishes the procedural safeguards required by Part C of the Individuals with Education Act, Pub.L. 108-446, Section 639.

(b) The necessity of this administrative regulation: Procedural safeguards are a required state component under 34 C.F.R. Subpart E 303.340 through 303.438.

(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 law.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation provides a description of the actions and requirements for the agency, early intervention provider and family while implementing procedural safeguards.

(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 amendments for this regulation reflect the changes made to the federal regulations and bring KEIS into compliance with those regulations.

(b) The necessity of the amendment to this administrative regulation: Changes are necessary to be in compliance with federal statute and regulation.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 200.650 to 200.676 requires the Cabinet to administer all funds appropriated to implement administrative regulations and promulgate regulations.

(d) How the amendment will assist in the effective administration of the statutes: These amendments will help to assure compliance with federal statute and regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by the administrative regulation: The affected entities include: The Cabinet for Health and Family Services (one state agency), fifteen (15) points of entry/local lead agencies, 1,500 providers and 6,000 children and their families.

(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 Cabinet for Health and Family Services will need to be prepared to implement mediation and due process if this is requested by a family when trying to resolve conflicts surrounding the early intervention services for their child. The Points of Entry/Local Lead Agencies will need to understand how to protect eligible children's rights and process a request for mediation and due process with the Cabinet. Providers and families will need to know how to request mediation or due process from the Cabinet. All stakeholders will need to learn how to file written complaints.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This regulation does allow the Cabinet to assess a fee of ten (10) dollars for a requested copy of the early intervention record. This shall not prevent the family from exercising the right to inspect and review those records. The Cabinet has legal services as part of the administrative structure of the agency.

(c) As a result of the compliance, what benefits will accrue to the entities identified in question (3): Families and providers will have rights protected and mediation and/or due process available when needed through the state lead agency.

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

(a) Initially: There are no costs to implement this regulation.

(b) On a continuing basis There are no costs to implement 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, state general funds, and Medicaid funds are used to support the early intervention system.

(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 amended regulation does allow the Cabinet to assess a family fee of ten (10) dollars for a requested copy of the early intervention record. There is no increase in funding to implement this amended administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This amended regulation does allow the Cabinet to assess a family fee of ten (10) dollars for a requested copy of the early intervention record.

(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. 1439, 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 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? There will be no revenue generated by this administrative regulation during 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 expenditures to implement this administrative regulation 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: There is no fiscal impact on local or state government for this administrative regulation.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 34 C.F.R. 303 Subpart E—Procedural Safeguards outlines the states responsibilities in assuring the rights of children and parents who receive early intervention services. This amendment ensures full compliance with the provisions under that part.

2. State compliance standards. KRS 200.672 charges the Cabinet for Health and Family Services, Department for Public Health to protect the rights of disabled child, parent, or guardian being served by the system.

3. Minimum or uniform standards contained in the federal mandate. By revising this administrative regulation to mirror the federal language regarding procedural safeguards the state will be in full compliance under this part of the federal statute.

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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Maternal and Child Health
(Amendment)

902 KAR 30:200. Coverage and payment for Services.

RELATES TO: KRS 200.654, 200.672, 34 C.F.R. 303.520, 303.521,[~~303.527, 303.528,~~] 20 U.S.C. 1438, 1440

STATUTORY AUTHORITY: KRS 194A.050, 200.654, 200.660(3), (7), (8)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 200.660 requires the Cabinet for Health and Family Services to administer funds appropriated to implement the provisions of KRS 200.650 to 200.676, to enter into contracts with service providers, and to promulgate administrative regulations necessary to implement KRS 200.650 to 200.676. This administrative regulation establishes the provisions relating to early intervention services for which payment shall be made on behalf of eligible recipients.

Section 1. Participation Requirements. An early intervention provider that requests to participate as an approved First Steps provider shall comply with the following:

(1) Submit to an ongoing review by the Department for Public

Health, or its agent, for compliance with 902 KAR Chapter 30;

(2)(a) Meet the qualifications for a professional or paraprofessional established in 902 KAR 30:150; or

(b) Employ or contract with a professional or paraprofessional who meets the qualifications established in 902 KAR 30:150;

(3) Ensure that a professional or paraprofessional employed by the provider who provides a service in the First Steps Program shall attend training on First Steps' philosophy, practices, and procedures provided by First Steps representatives prior to providing First Steps services;

(4) Agree to provide First Steps services as authorized by an individualized family service plan as required by 902 KAR 30:130;

(5) Agree to maintain and to submit as requested by the Department for Public Health required information, records, and reports to ensure compliance with 902 KAR Chapter 30;

(6) Establish a contractual arrangement with the Cabinet for Health and Family Services for the provision of First Steps services; and

(7) Agree to provide upon request information necessary for reimbursement for services by the Cabinet for Health and Family Services in accordance with this administrative regulation, which shall include the tax identification number and usual and customary charges.

Section 2. Reimbursement. The Department for Public Health shall reimburse a participating First Steps provider the lower of the actual billed charge for the service or the fixed upper limit established in this section for the service being provided. (1) A charge submitted to the Department for Public Health shall be the provider's usual and customary charge for the same service.

(2) The fixed upper limit for services shall be as established in this subsection.

(a) Initial evaluation[~~Service coordination. Primary service coordination shall be provided by face-to-face contact or by telephone on behalf of a child, with the parent of the child, a professional or other service provider, or other significant person in the family's life.~~

~~1. In the office, the fee shall be sixty-two (62) dollars and fifty (50) cents per hour of service.~~

~~2. In the home or community site, the fee shall be eighty-five (85) dollars per hour of service. (b) Primary level evaluation~~]. The developmental component of the initial[~~primary level~~] evaluation for a child without an established risk condition shall be provided by face-to-face contact with the child and parent.

1. In the office or center-based site, the fee shall be $270 per service event.

2. In the home or community site, the fee shall be $270 per service event.

(b)[~~(c)~~] Five (5) Area Assessment. The developmental component of the initial[~~primary level~~] evaluation for the child with an established risk condition shall be provided by face-to-face contact with the child and parent.

1. In the office or center-based site, the fee shall be $175 per service event.

2. In the home or community-based site, the fee shall be $175 per service event.

(c) Annual or exit assessment. The annual or exit assessment conducted by the primary service provider shall be provided by face-to-face contact with the child and parent.

1. In the office or center-based site, the fee shall be $175 per service event.

2. In the home or community-based site, the fee shall be $175 per service event.

(d) Discipline specific assessment. The discipline specific assessment conducted by a direct service provider shall be provided by face-to-face contact with the child and parent.

1. In the office or center-based site, the fee shall be $175 per service event.

2. In the home or community-based site, the fee shall be $175 per service event.

(e)[~~(d)~~] Record review. A record review shall be provided by a Department for Public Health approved team and paid at the contracted amount.[~~The fee shall be $300 per service event.~~]

(f)[~~(e)~~] Intensive clinic evaluation. The intensive level evaluation shall be provided by a Department for Public Health approved team and shall include face-to-face contact with the child and parent.

1. In the office or center-based site, which involves a board certified physician, the fee shall be $1,100 per service event.

2. In the community site, which involves a board certified physician, the fee shall be $1,100 per service event.

(g)[~~(f)~~] Early intervention[~~, service assessment,~~] or collateral services in accordance with Section 3(1), (2), (4) and (5) of this administrative regulation shall have the fixed upper limits established in this paragraph.

1. For an audiologist:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63) dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89) dollars per hour of service.

2. For a marriage and family therapist:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~]or an early intervention service including cotreatment shall be sixty-three (63) per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89) per hour of service.

3. For a licensed psychologist, a licensed psychological practitioner, a licensed professional clinical counselor, or certified psychologist with autonomous functioning:

a. In the office or center based site, the fee for a [~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63) dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89) dollars per hour of service.

4. For a licensed psychological associate or a certified psychologist:

a. In the office or center-based site, the fee for a collateral service or an early intervention service including cotreatment shall be sixty-one (61) dollars per hour of service; or

b. In the home or community site, the fee for a collateral service or an early intervention service including cotreatment shall be eighty-one (81) dollars per hour of service.

5. For a developmental interventionist:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63)[~~sixty-one (61)~~] dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89)[~~eighty-one (81)~~] dollars per hour of service.

6.[~~For a developmental associate in a center based site, the fee for a collateral service or an early intervention service including cotreatment shall be twenty-four (24) dollars per hour of service.~~

~~7.~~] For a registered nurse:

a. In the office or center based site, the fee for a[~~Service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63) dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89) dollars per hour of service.

7.[~~For a licensed practical nurse:~~

~~a. In the office or center based site, the fee for a collateral service or an early intervention including cotreatment shall be twenty-four (24) dollars per hour of service; or~~

~~b. In the home or community site, the fee for a collateral service or an early intervention including cotreatment shall be thirty-two (32) dollars per hour of service.~~

~~9. For a nutritionist:~~

~~a. In the office or center based site, the fee for a service assessment, collateral service, or an early intervention including cotreatment shall be sixty-three (63) dollars per hour of service; or~~

~~b. In the home or community site, the fee for a service assessment, collateral service, or an early intervention including cotreatment shall be eighty-nine (89) dollars per hour of service. 10.~~] For a dietitian:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63) dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89) dollars per hour of service.

8.[~~11.~~] For an occupational therapist:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63) dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89) dollars per hour of service.

9.[~~12.~~] For an occupational therapy assistant:

a. In the office or center based site, the fee for a collateral service or an early intervention service including cotreatment shall be forty-six (46) dollars per hour of service; or

b. In the home or community site, the fee for a collateral service or an early intervention service including cotreatment shall be seventy (70) dollars per hour of service.

10.[~~13.~~] For an orientation and mobility specialist:

a. In the office or center-based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63)[~~sixty-one (61)~~] dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89)[~~eighty-one (81)~~] dollars per hour of service.

11.[~~14.~~] For a physical therapist:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63) dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89) dollars per hour of service.

12.[~~15.~~] For a physical therapist assistant:

a. In the office or center based site, the fee for a collateral service or an early intervention service including cotreatment shall be forty-six (46) dollars per hour of service; or

b. In the home or community site, the fee for a collateral service or an early intervention service including cotreatment shall be seventy (70) dollars per hour of service.

13.[~~16.~~] For a speech therapist:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63) dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89) dollars per hour of service.

14.[~~17.~~] For a social worker:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-one (61) dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-one (81) dollars per hour of service.

15.[~~18.~~] For a teacher of the deaf and hard of hearing:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63)[~~sixty-one (61)~~] dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89)[~~eighty-one (81)~~] dollars per hour of service.

16.[~~19.~~] For a teacher of the visually impaired:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-three (63)[~~sixty-one (61)~~] dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-nine (89)[~~eighty-one (81)~~] dollars per hour of service.

17.[~~20.~~] For a physician or a nurse practitioner providing a collateral service in the office or center based site, the fee shall be seventy-six (76) dollars per hour of service. A physician or a nurse practitioner shall not receive reimbursement for early intervention.

18.[~~21.~~] For an assistive technology specialist:

a. In the office or center based site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be sixty-one (61) dollars per hour of service; or

b. In the home or community site, the fee for a[~~service assessment,~~] collateral service[~~,~~] or an early intervention service including cotreatment shall be eighty-one (81) dollars per hour of service.

19. For a sign language and cued language specialist:

a. In the office or center based site, the fee for a collateral service or an early intervention service including cotreatment shall be sixty-three (63) dollars per hour of service; or

b. In the home or community site, the fee for a collateral service or an early intervention service including cotreatment shall be eighty-nine (89) dollars per hour of service.

20.[~~22.~~] For an optometrist or ophthalmologist providing collateral service in an office or center based site, the fee shall be sixty-three (63) dollars per hour of service. An optometrist or ophthalmologist shall not receive reimbursement for early intervention.

(h)[~~(g)~~] Respite shall be seven (7) dollars and sixty (60) cents per hour.

(3)(a) For early intervention[~~, service assessment,~~] or collateral services, hours shall be determined using the beginning and ending time for a service.

1. Services shall be documented in the First Steps data management system and shall include a list of all those present during the session, a description of each early intervention service provided, the child's response, and future action to be taken. Service documentation shall be entered within five (5) calendar days of the service delivery date.

2. The hours shall be computed as follows:

a. Fifteen (15) to twenty-nine (29) minutes shall equal 0.25 hours;

b. Thirty (30) to forty-four (44) minutes shall equal 0.50 hours;

c. Forty-five (45) to fifty-nine (59) minutes shall equal 0.75 hours; and

d. Sixty (60) to seventy-four (74) minutes shall equal 1.00 hour.

(b) For service coordination services, hours shall be determined using the beginning and ending time for a service documented in staff notes in accordance with paragraph (a) of this subsection.

1. The hours shall be computed as follows:

a. One (1) to twenty-two (22) minutes shall equal 0.25 hours;

b. Twenty-three (23) to thirty-seven (37) minutes shall equal 0.50 hours;

c. Thirty-eight (38) to fifty-two (52) minutes shall equal 0.75 hours; and

d. Fifty-three (53) to sixty-seven (67) minutes shall equal 1.00 hour.

2. Service coordination minutes spent over the course of a day

on a child or family shall be accumulated at the end of the day in order to determine the total number of hours spent.

(4) A payment for a discipline specific assessment, five (5) area assessment, annual or exit assessment, initial[~~primary~~] or intensive evaluation listed in subsection (2) of this section shall be based on a complete evaluation as a single unit of service. An individual provider shall not be reimbursed for participation on the intensive evaluation team.

(5) Payment for assistive technology devices shall be made in accordance with 902 KAR 30:130, Section 3.

(a) The total rental cost of an assistive technology device shall not exceed the purchase price of that device. The length of rental shall be based on the purchase price of the device and shall not exceed ten (10) months in length.

(b) The total purchase cost of an assistive technology device shall include the actual cost of the item being purchased, all related shipping charges, and an administrative fee not to exceed ten (10) percent.

(6) Payment for transportation shall be the lesser of the billed charge or:

(a) For a commercial transportation carrier, an amount derived by multiplying one (1) dollar by the actual number of loaded miles using the most direct route;

(b) For a private automobile carrier, an amount equal to twenty-five (25) cents per loaded mile transported; or

(c) For a noncommercial group carrier, an amount equal to fifty (50) cents per eligible child per mile transported.

(7) A payment for a group intervention service shall be thirty-two (32) dollars per child per hour of direct contact service for each child in the group with a limit of three (3) eligible children per professional or paraprofessional who can practice without direct supervision.

Section 3. Limitations. (1) Service Assessments.

(a)[~~Payment shall be limited to no more than two (2) hours per child per discipline per assessment unless preauthorized by the Department for Public Health in accordance with Section 4 of this administrative regulation. (b)~~] Payment for a discipline specific assessment shall be limited to three (3) assessments per discipline per child, unless additional hours are necessary based on the reasons listed in paragraph (b)[~~subsection (c)~~] and documented in accordance with 902 KAR 30:130, Section 1(7)[~~(5)~~] from birth to the age of three (3) unless preauthorized by the Department for Public Health in accordance with Section 4 of this administrative regulation.

(b)[~~(c)~~]1. A service assessment payment shall not be made for the provision of routine early intervention services by a discipline in the general practice of that discipline.

2. Payment for a service assessment shall be restricted to the need for additional testing due to new concerns or significant change in the child's status.

3. Routine activity of assessing progress and outcomes shall be billed as early intervention.[~~(d) Payment shall be limited to an assessment provided as a face-to-face contact with the child and parent, and shall not exceed two (2) hours for each event.~~

~~(e) Payment for a service assessment of up to two (2) hours for each event for the purpose of the annual and exit progress monitoring five (5) area assessment shall be made to the primary service provider as approved by the IFSP team.~~]

(2) For early intervention, unless prior authorized by the Department for Public Health in accordance with Section 4 of this administrative regulation, limitations for payment of services shall be as established in this subsection.

(a) For office, center, or home and community sites:

1. Payment shall be limited to no more than one (1) hour per day per child per discipline by a:

a. Professional meeting the qualifications established in 902 KAR 30:150; or

b. Paraprofessional meeting the qualifications established in 902 KAR 30:150.

2. Payment shall be limited to no more than twenty-four (24) hours for a single discipline and thirty-six (36) hours for more than one (1) discipline during a six (6) month period and for group shall be limited to an additional forty-eight (48) hours during a six (6) month period.

(b) For group:

1. Children shall not be eligible for both group and individual early intervention services by the same discipline concurrently on the Individualized Family Services Plan.

2. Group service shall be provided by enrolled First Steps providers in accordance with 902 KAR 30:150, Section 1(11). The ratio of staff to children in group early intervention shall be limited to a maximum of three (3) children per professional and paraprofessional per group.

(c) Payment for siblings seen at the same time shall be calculated by dividing the total time spent by the number of siblings to get the amount of time to bill per child.

(d) Payment for a service shall be limited to a service that is authorized by the[~~entire~~] IFSP team in accordance with 902 KAR 30:130, Section 3(3)[~~2(6) or (7)~~].

(e) 1. Except as provided in subparagraph 2. of this paragraph, payment shall be limited to a service provided as a face-to-face contact with the child and either the child's parent or caregiver.

2. Early intervention family services authorized by KRS 200.654(7) may be provided without the child present if the reason the child's presence is clinically contraindicated is documented in the session note.

(3) For respite, payment shall:

(a) Be limited to no more than eight (8) hours of respite per month, per eligible child;

(b) Not be allowed to accumulate beyond each month; and

(c) Be limited to families in crisis, or strong potential for crisis without the provision of respite.

(4) For collateral services, payment for collateral services shall be a billable service for First Steps providers, who are providing early intervention services for the eligible child through an IFSP and paid by the First Steps system.

(a) The length of an IFSP meeting shall be limited to no more than one (1) hour.

(b) Payment for attendance at one (1) Admissions and Release Committee (ARC) meeting held prior to a child's third birthday shall be limited to the service coordinator and primary service provider selected by the IFSP team.

(c) Participation at an initial IFSP meeting by an initial[~~a primary level~~] evaluator shall be limited to an evaluator who conducted the initial evaluation[~~has provided feedback and interpretation of the evaluation to the family prior to the IFSP meeting~~] in accordance with 902 KAR 30:120, Section 2(5)(a)[~~(3)(d)~~]. Payment shall be at the collateral services rate for the discipline that the evaluator represents.

[~~(d) A face-to-face attendance at an IFSP meeting or a face-to-face or telephone consultation by a team member with a child's physician for developmentally-related needs shall be provided.~~]

(5) For cotreatment, payment shall be limited to three (3) disciplines providing services concurrently.

(6) Unless prior authorized by the Department for Public Health due to a shortage of direct service providers, an initial[~~a primary level~~] evaluator shall not be eligible to provide early intervention to a child whom the evaluator evaluated and which resulted in the child becoming eligible.

Section 4. Prior Authorization Process. (1) Authorization for payment for early intervention services beyond the limits established in Section 3 of this administrative regulation shall be submitted to the cabinet or its designee, as determined by the Department for Public Health, and approved prior to the service being delivered and shall include the following:

(a) A service exception request completed in the First Steps data management system; and

(b) The Record Review Supporting Documentation[~~, which shall include three (3) sections~~:

~~1. The Payor of Last Resort;~~

~~2. Transfer of Skills; and~~

~~3. The Service Planning Activity Matrix~~].

(2) The record review team shall issue a written recommendation for the IFSP team to consider within ten (10) calendar days of receipt of the request.

(3) If the IFSP team is not in agreement with the recommenda-

tion of the record review team:

(a) A request for further review shall be submitted to the Department for Public Health; and

(b) A three (3) person team from the Department for Public Health, Division of Maternal and Child Health, including the division director, shall render a recommendation.

(4) If the IFSP team is not in agreement with the three (3) person team recommendation established in subsection (3)(b) of this section:

(a) The child's IFSP team shall be asked to reconvene for an IFSP meeting with a representative from the record review team and a representative from the three (3) member team; and

(b) If the IFSP team concludes at that IFSP meeting that the services are still needed, payment for the service shall be authorized for the duration of the current IFSP.

Section 5. System of Payment and Fees[~~Sliding Fee~~]. (1) All families enrolling in the First Steps system shall be assessed for the family's ability to pay a participation fee for early intervention services in accordance with KRS 200.654(7)(f) to (m) and shall receive a copy of the Your Financial Responsibilities in First Steps brochure.

(2) A charge to the family[~~Families shall pay for services based on a sliding fee scale, except that a charge~~] shall not be made for the following functions:

(a) Child find;

(b) Evaluation and assessment;

(c) Service coordination; and

(d) Administrative and coordinative activities including development, review, and evaluation of individualized family service plans, and the implementation of procedural safeguards.

(3)[~~(2)~~] Payment of fees shall be for the purpose of:

(a) Maximizing available sources of funding for early intervention services; and

(b) Giving families an opportunity to assist with the cost of services if there is a means to do so, in a family share approach.

(4)[~~(3)~~] The family share payment shall:

(a) Be based on a sliding fee scale;

(b) Be explained to the family by the service coordinator; and

(c)[~~(b) Be an income-based monthly fee, and with the exception established in paragraph (d) of this subsection, shall~~] Begin in the month of the IFSP, at the time early intervention services are authorized, and continue for the duration of participation in early intervention services.

(5) The ability to pay shall:

(a) Be based on the level[~~, as determined by the: 1. Level~~] of the family gross income identified on the last Federal Internal Revenue Service statement or check stubs from the four (4) most recent consecutive pay periods, as reported by the family; and

(b) The[~~2.~~] level of income matched with the level of poverty, utilizing the federal poverty guidelines as published annually by the Federal Department of Health and Human Services, based on the following scale:

1.[~~a.~~] Below 200 percent of poverty, there shall be no payment;

2.[~~b.~~] From 200 percent of poverty to 299 percent, the payment shall be twenty (20) dollars per month of participation;

3.[~~c.~~] From 300 percent of poverty to 399 percent, the payment shall be thirty (30) dollars per month of participation;

4.[~~d.~~] From 400 percent of poverty to 499 percent, the payment shall be forty (40) dollars per month of participation;

5.[~~e.~~] From 500 percent of poverty to 599 percent, the payment shall be fifty (50) dollars per month of participation; or

6.[~~f.~~] From 600 percent of poverty and over, the payment shall be $100 per month of participation.

(6) The family share participation fee shall not:

(a) Exceed the cost of the actual monthly Part C service;

(b)[~~; (c) Not apply to a child receiving Medicaid or Kentucky Children's Health Insurance Program (KCHIP) benefits;~~

~~(d) Not~~] Apply to a family who receives only evaluation, assessment, service coordination services, or IFSP development in the initial calendar month of eligibility. The service coordinator shall notify the Department for Public Health First Steps Family Share Administrator immediately if the initial IFSP date is different than the month that early intervention services are started;

(c)[~~(e) Not~~] Apply to a family that does not receive services except those described in paragraph (b)[~~(d)~~] of this subsection for at least one (1) month if prior authorized by the Department for Public Health First Steps Family Share Administrator in accordance with paragraph (d)[~~(g)~~]1 and 2 of this subsection. A request shall not be submitted for a retroactive period unless an extenuating circumstance occurs such as an unexpected hospitalization; or

(d)[~~(f) Not apply to a family that receives evaluation, assessment, service coordination, or IFSP development if the developmental evaluation or assessment did not reveal a developmental delay. The service coordinator shall notify the Department for Public Health First Steps Family Share Administrator immediately if this situation exists so that the family is not assessed a family share cost; and~~

~~(g) Not~~] Prevent or delay a child from receiving services if the family shows to the satisfaction of the Department for Public Health an inability to pay, in accordance with the following:

1. The service coordinator shall submit to the Department for Public Health First Steps Family Share Administrator, on behalf of the family, a waiver request to have the amount of the family share payment reduced or eliminated for a period not to exceed three (3) calendar months. A request shall not be submitted for a retroactive period unless extenuating circumstances, such as an unexpected hospitalization, occurs; and

2. The family shall undergo a financial review by the Department for Public Health that may:

a.(i) Adjust the gross household income by subtracting extraordinary medical costs, equipment costs, exceptional child care costs, and other costs of care associated with the child's other family members' disabilities; and

(ii) Result in a calculation of a new family share payment amount based on the family's adjusted income compared to the percentage of the poverty level established in paragraph (b)2 of this subsection. If a recalculation is completed, the Department for Public Health shall conduct a review at least quarterly; or

b. Suspend or reduce the family share payment, based on a verified financial crisis that would be exacerbated by their obligated family share payment. The Department for Public Health shall conduct a review at least quarterly.

(7) In accordance with 902 KAR 30:180, the family may contest the imposition of a fee or the determination of their ability to pay by filing:

(a) A request for mediation;

(b) A request for a due process hearing;

(c) An administrative complaint; or

(d) An appeal to the Part C Coordinator for final resolution.

(8)[~~(4)~~] Income and insurance coverage shall be verified at six (6) month intervals, and more often if changes in household income will result in a change in the amount of the obligated family share payment.

(9)[~~(5)~~] A family that refuses to have its income verified shall be assessed a family share payment of $100 per month of participation.

(10)[~~(6)~~] If multiple children in a family receive early intervention services, the family share payment shall be the same as if there were one (1) child receiving services.

(11)(a)[~~(7)~~] If a family has the ability to pay the family share but refuses to do so for three (3) consecutive months, the family shall receive service coordination, IFSP development, procedural safeguards, and assessment services only until discharged from the program or the family share balance is paid in full, whichever occurs first.

(b) The service coordinator shall provide the family a financial notice of action at thirty (30) calendar days prior to the suspension of ongoing IFSP services.

Section 6. Use of Insurance. (1) Public Insurance.

(a) The state lead agency shall be the enrolled Medicaid provider for early intervention services. A contracted provider or agency shall not bill Medicaid directly for early intervention services provided in accordance with the IFSP.

(b) Written notification in accordance with 34 C.F.R. 303.520(3)(i)-(iv) shall be provided to the child's parent or guardian before the use of public benefits or insurance to pay for early inter-

vention services.

(c) A parent or guardian shall not be required to sign up for or enroll in public benefits or insurance programs as a condition of receiving early intervention services.

(2) Private Insurance.

(a) Parent or guardian consent shall be obtained:

1. For the use of private insurance to pay for the initial provision of an early intervention service on the IFSP; and

2. Each time consent for services is required due to an increase in the frequency, length, duration, or intensity in the provision of service in the child's IFSP.

(b)[(8)] A family who chooses to use private insurance for payment of a First Steps service shall not be responsible for payment of insurance deductibles or copayments related to this service.

(c) The fee paid to the early intervention provider by KEIS shall include any co-pay or deductible associated with the services, bringing the total to the maximum rate for KEIS allowed by Section 2 of this administrative regulation. Families shall be responsible for payment of their insurance premiums and may incur a decrease in the annual cap for certain services under their policy.

(d) A family who has the ability to pay and does not give consent for the use of private insurance shall receive only those services provided at no cost to the family as described in Section 5(2) of this administrative regulation.

(e) If a family is assessed as having an inability to pay and does not give consent for the use of private insurance, this lack of consent shall not prevent or delay a child from receiving services.

(f) If a family receives payment from insurance, these funds shall be surrendered to the early intervention provider for services rendered. Failure to surrender the payment shall result in the amount of the insurance payment being added to the family share balance due.

(g)[(9) With the exception of a discipline identified in 902 KAR 30:130, Section 2(8)(g)2.i., j., or k.,] A provider shall bill a third-party insurance[, if any,] for an early intervention service prior to billing First Steps. Documentation regarding the billing, the third-party insurance representative's response, and payment, if any, shall be maintained in the child's record and submitted through the First Steps data management system.

Section 7.[6.] Incorporation by Reference. (1) The following material is incorporated by reference:

(a)[The] "Record Review Supporting Documentation", July 2012; and

(b) "Your Financial Responsibilities in First Steps", July 2012[November 2010, is incorporated by reference].

(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: May 14, 2013

FILED WITH LRC: May 15, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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

(1) Provide a brief summary of 902 KAR 30:200:

(a) What this administrative regulation does: This administrative regulation establishes the rates to be paid to providers for the provision of approved services (i.e. Physical Therapy, Occupational Therapy), sets forth limitations for billable services, and establishes processes for requesting services beyond set parameters and for assessing and collecting family participation payments.

(b) The necessity of this administrative regulation: 902 KAR 30:200 is necessary because the First Steps program operates on a fee-for-service system requiring the establishment of rates for covered services.

(c) How this administrative regulation conforms to the content of the authorizing statute: KRS 200.660 assigns the Cabinet for Health and Family Services the duty of appropriately administering all funds related to the implementation of the First Steps program. Further, KRS 200.660 directs the Cabinet for Health and Family Services to develop and implement a sliding fee scale in accordance with federal regulation, and contract with providers to provide First Steps services.

(d) How this administrative regulation currently assists in the effective administration of the statutes: This administrative regulation describes the rate structure used by the Cabinet for Health and Family Services when contracting with service providers as well as the sliding fee scale.

(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 amendment to this administrative regulation removes the payment rate for those disciplines that have been removed from 902 KAR 30:150 and establishes the rate for those disciplines that were added to that same administrative regulation. It sets the rate for all assessments as a single flat rate. Cost limitations for both the rental and purchase of assistive technology devices have been added to this administrative regulation. The release of updated federal regulations expanded the required components for a state's system of payment and this regulation was amended to reflect these required changes.

(b) The necessity of the amendment to this administrative regulation: The revisions to this administrative regulation are necessary to establish business rules for providers and establish rates of payments for services rendered. Obsolete language is removed to reflect current program structure and provide clarity.

(c) How the amendment conforms to the content of the authorizing statute: KRS 200.660 assigns the Cabinet for Health and Family Services the duty of appropriately administering all funds related to the implementation of the First Steps program. Further, KRS 200.660 directs the Cabinet for Health and Family Services to develop and implement a sliding fee scale in accordance with federal regulation, and contract with providers to provide First Steps services. KRS 200.650 (6) and KRS 200.652 (3) require a statewide 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: These amendments will help to assure appropriate compensation to First Steps service provider and will assure that the Cabinet for Health and Family Services is administering the sliding fee scale in a manner consistent with federal regulation and intent.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by the administrative regulation: Approximately 1,500 early intervention providers, including Point of Entry staff, will be affected by these regulations. Over 6,000 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 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: Providers of the amended rates will need to adjust their claims to reflect the changes. Providers who are qualified to provide sign language and cued language services will need to enroll. Families of children who qualify for Medicaid will have to give consent for the release of the child's protected health information before KEIS can submit a claim for reimbursement to Medicaid. Families may contest the imposition of a family share cost participation fee. And those families who receive direct payment for services from their insurance policy will be required to surrender those payments to the early intervention provider.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The Kentucky Early Intervention System currently costs approximately $40 million dollars. The revisions to this administrative regulation do not cost the entities affected by the amended regulations any additional dollars.

(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.

(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 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 any 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 fifteen (15) local Point of Entry, approx. 1,500 direct service providers, families receiving early intervention services, 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. 1438, 1440, 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 revenue generated by this administrative regulation 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? There will be no revenue generated by this administrative regulation during 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 the 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: There is no fiscal impact on local or state government for this administrative regulation.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 34 C.F.R. 303.500 through 303.521 outlines the federal policies and procedures related to financial matters. It states that First Steps must be the payor of last resort. It also provides provisions for charging a family participation fee. This amendment ensures full compliance with the provisions under that part.

2. State compliance standards. KRS 200.674 charges the Cabinet for Health and Family Services, Department for Public Health in the use of early intervention funds.

3. Minimum or uniform standards contained in the federal mandate. By revising this administrative regulation, Kentucky is in full compliance with the federal requirements to ensure First Steps is the payor of last resort for early intervention services.

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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Administration and Financial Management
(Amendment)

907 KAR 1:563. Medicaid covered services[~~hearings and~~] appeals and hearings unrelated to managed care.

RELATES TO: KRS Chapter 13B, 194A.025, 205.231, 205.237, 42 C.F.R. Part 475, 483.12, 431 Subpart E, 483 Subpart E, 42 U.S.C. 1396n(c)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(2) and (3), 205.6315, 42 U.S.C. 1396[~~(3), EO-2004-726~~]

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 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[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes policies and requirements[~~provisions~~] relating to an adverse action, an appeal, or a hearing regarding[~~the~~] Medicaid covered services that are not the responsibility of a managed care organization[~~hearing and appeal process for applicants and recipients~~].

Section 1. Definitions. (1) "1915(c) home and community based waiver service" means a service available or provided via a 1915(c) home and community based waiver services program.

(2) "1915(c) home and community based waiver services program" means a Kentucky Medicaid program established pursuant

to and in accordance with 42 U.S.C. 1396n(c).

(3) "Applicant" means an individual who has applied for Medicaid covered services.

(4)[(2)] "Authorized representative" means an individual or entity[guardian] acting on behalf of, and with written consent from, a recipient or applicant.

(5) "Cabinet" means the Cabinet for Health and Family Services.

(6)[(3)] "Department" means the Department for Medicaid Services or its designee.

(7) "Enrollee" means a recipient who is enrolled with a managed care organization for the purpose of receiving Medicaid or Kentucky Children's Health Insurance Program covered services.

(8) "Hearing" means cabinet level administrative hearing.

(9) "ICF IID" means intermediate care facility for an individual with an intellectual disability.

(10) "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.

(11)[(4)] "Medicaid covered services" means items or services a Medicaid recipient may receive through the Medicaid Program.

(12) "PASRR" means preadmission screening and resident review.

(13) "Patient liability" means the financial obligation of a recipient towards the cost of the recipient's nursing facility services.

(14) "Provider" is defined by KRS 205.8451(7).

(15) "QIO" or "quality improvement organization" means an entity that meets the requirements established in 42 C.F.R. 475.101.

(16) "Recipient" is defined by KRS 205.8451(9).

(17)[(5) "Member" means a Medicaid recipient who is enrolled in a partnership or a managed behavioral healthcare organization.

(6) "Peer review organization" means a federally designated organization that is performing the utilization review functions for the department.

(7) "Recipient" means an individual who receives Medicaid.

(8)] "Secretary" means the Secretary of the Cabinet for Health and Family Services.

(18)[(9)] "Time-limited benefits" means Medicaid coverage which is restricted to a specified period in time.

Section 2. Informing the Recipient of Medicaid Coverage Hearing Rights. (1) An applicant, recipient, or authorized representative[guardian] shall be informed, in writing, of the applicant's or recipient's right to a hearing[of his right to a cabinet level administrative hearing in writing] if an adverse action is taken affecting covered services.

(2) An applicant, recipient, or authorized representative[guardian] shall be informed of the method by which the applicant or recipient[he] may obtain a hearing and that the applicant or recipient[he] may be represented by:

(a) Legal counsel;

(b) A relative;

(c) A friend;

(d) A[Other] spokesperson not listed in paragraph (a), (b), (c), (e), or (f);

(e) An authorized representative; or

(f) Himself or herself.

(3) An adverse action[The] notice shall contain a statement of:

(a) The Medicaid adverse action;

(b) The reason for the action;

(c) The specific federal or state law or administrative regulation that supports the action; and

(d) An explanation of the circumstances under which payment for services shall be continued if a hearing is requested in a timely manner pursuant to[timely in accordance with] Section 5 of this administrative regulation.

Section 3. Notification Process. (1) An adverse action notice regarding an applicant or a recipient shall be mailed to the applicant, recipient, or authorized representative of the applicant or recipient using:

(a) The United States Postal Service; and

(b) A return receipt requested format.

(2) Refusal by an applicant, a recipient, or an authorized representative to confirm receipt of an adverse action notice shall be considered receipt of the adverse action notice[an applicant or a recipient using the United States Postal Service.

(2) An adverse notice to an applicant, recipient or responsible party covered under Section 5(1) of this administrative regulation shall be sent using a return receipt requested format].

Section 4. Request for a Hearing. (1) An applicant, recipient, or an authorized representative may request a hearing by filing a written request with the department.

(2) If an applicant, recipient, or authorized representative requests a hearing, the request shall:

(a) Be in writing and clearly specify the reason for the request;

(b) Indicate the date of service or type of service for which payments may be denied; and

(c) Be postmarked within thirty (30) calendar days from the date of the department's written notice of adverse action of:

1. Discontinuance of services;

2. Adverse determination made with regard to the PASRR requirements of 42 U.S.C. 1396r(e); or

3. Patient liability.

Section 5. Continuation of Medicaid Covered Services. (1) If a[the] request for a[cabinet level administrative] hearing is postmarked or received within ten (10) days of the advance notice date of denial for any of the following types of denials, the individual shall remain eligible for the care, program participation, or service denied until the date that the final hearing decision order is rendered in accordance with Section 9 of this administrative regulation:

(a) Denial that an individual meets patient status criteria to qualify for nursing facility services pursuant to 907 KAR 1:022;

(b) Denial that an individual meets patient status criteria to qualify for ICF IID services pursuant to 907 KAR 1:022;

(c) Denial that an individual meets nursing facility level of care criteria, nursing facility patient status criteria, or ICF IID patient status criteria pursuant to 907 KAR 1:022 to qualify for home and community based waiver services; or

(d) Denial of a home and community based waiver service[specified on the notice for denial of level of care, a Medicaid vendor payment for nursing facility, intermediate care facility for the mentally retarded and developmentally disabled, or home- and community-based waivers services shall continue until the date the final cabinet level hearing decision order is rendered in accordance with Section 9 of this administrative regulation].

(2) Subsection (1) of this section shall not apply to a Medicaid Program service not stated in subsection (1) of this section.

(3) Subsection (1) of this section shall not apply if the Medicaid Program service has been reduced or discontinued as a result of a change in law or administrative regulation.

(4) Time-limited benefits shall not be extended based on a request for a hearing.

(5) If a request for a[the request for a cabinet level administrative] hearing is postmarked or received from a recipient within ten (10) days of the advance notice of an adverse PASRR determination made in the context of a resident review, the department shall continue to reimburse[a Medicaid vendor payment] for nursing facility services[shall continue] until the date that the final[the cabinet level administrative] hearing decision is rendered.

Section 6. Notice of Scheduled Hearing. (1) A[The] scheduled hearing notice shall contain:

(a) The date, time, and place of the scheduled hearing; and

(b) A statement that the local Department for Community Based Services[Social Insurance] office provides information regarding the availability of free representation by legal aid or a welfare rights organization within the community.

(2)(a) A[cabinet level administrative] hearing shall be conducted within thirty (30) days of the date of the request for a hearing.

(b)[and] A decision shall be issued within thirty (30) days of the hearing date, except for a hearing decision regarding:

1. A nursing facility level of care or patient status decision;

2. An ICF IID patient status decision;

3. A nursing facility level of care, nursing facility patient status, or ICF IID patient status decision related to 1915(c) home and community based waiver program participation; or

4. A 1915(c) home and community based waiver service.

(c) A hearing decision regarding an item listed in paragraph (b) of this subsection shall be issued within fifteen (15) calendar days of the date of request for the hearing[~~that a hearing decision regarding vendor payments to the following shall be issued within fifteen (15) days:~~

~~(a) Nursing facilities;~~

~~(b) Intermediate care facility for the mentally retarded and developmentally disabled; or~~

~~(c) Community based waiver services~~].

(3) An applicant or recipient shall receive notice consistent with KRS 13B.050 including the right to:

(a) Legal counsel or other representation;

(b) Review the case record relating to the issue; and

(c) Submit additional information in support of the applicant's or recipient's[~~his~~] claim.

(4) If a[~~the~~] hearing involves medical issues:

(a) A medical assessment by an independent physician participating in the Medicaid Program shall be obtained at the department's expense if the hearing officer considers it necessary based on case record review;

(b) If an independent physician assessment at the department's expense is requested by the recipient or authorized representative and is denied by the hearing officer, notification of the reason for denial shall be established[~~set forth~~] in writing.

Section 7. Conduct of a Hearing. (1) A[~~The cabinet level administrative~~] hearing shall be conducted in accordance with the requirements of KRS 13B.080 and 13B.090.

(2) A[~~Impartiality. The cabinet level~~] hearing officer shall be impartial and shall disqualify himself or herself as required by KRS 13B.040.

(3) A[~~The cabinet level administrative~~] hearing shall be conducted in-state where the recipient or authorized representative may attend without undue inconvenience.

(4) A[~~The~~] hearing officer shall offer to transmit a[~~the~~] hearing decision by electronic format.

(5) If necessary to receive full information on the issue, a[~~the administrative~~] hearing officer may examine each party who appears and the party's[~~his~~] witnesses.

(6)(a) A[~~The administrative~~] hearing officer may reopen the hearing and take additional evidence as is deemed necessary.

(b) Evidence shall be taken in accordance with the provisions of KRS 13B.080 and 13B.090.

Section 8. Withdrawal or Abandonment of Request. (1) A[~~The~~] recipient or authorized representative:

(a) May withdraw the appeal for a hearing prior to the release of the hearing officer's decision; and

(b) Shall be granted the opportunity to discuss withdrawal with the recipient's[~~his~~] legal counsel or authorized representative prior to finalizing the action.

(2)[~~Abandonment of request.~~] A hearing request shall be considered abandoned if the recipient or authorized representative fails without prior notification to report for the hearing.

Section 9. The Cabinet Level Decision. (1) After a[~~the~~] hearing is concluded, the hearing officer shall issue a recommended decision.

(2) If a party wishes to file an exception, the exception[~~Exceptions~~] shall be filed with the cabinet within fifteen (15) days from the recommended decision.

(3) A final order shall be issued within ninety (90) days from the date of the request for a hearing.

(4) A copy of the recommended decision and a copy of the final order shall be mailed to the recipient and the recipient's authorized representative if applicable[~~his representative~~].

(5) If requested during the hearing, a copy of the recommended decision and the final order shall be electronically transmitted to a site specified by the applicant or recipient on the:

(a) Date the recommended decision is rendered; and

(b) Date the final order is rendered[~~dates the recommended decision is rendered and the date the final order is rendered to a site specified by the applicant or recipient~~].

Section 10. Appeal of[~~Cabinet Level~~] Hearing Decision. (1) A[~~The~~] final order, with respect to the issue considered, shall be final regarding continuation of a service or service reimbursement[~~vendor payments~~].

(2) A further appeal at the circuit court level may be initiated within thirty (30) days from the date of mailing of the decision in accordance with KRS 13B.140 and 13B.150.

(3) Information regarding free legal aid and welfare rights organizations may be obtained in accordance with Section 6(1) of this administrative regulation.

Section 11. Medicaid Case Actions Following Circuit Court Level Appeal Decision. (1) For a reversal involving a reduction of Medicaid coverage, action shall be taken to restore services within ten (10) days of the receipt of the circuit court decision.

(2) If a recipient continues to:

(a) Remain in a nursing facility or an ICF IID during the circuit court appeal process, the department shall reimburse for the nursing facility services or ICF IID services which occurred during the circuit court appeal process; or

(b) Receive a 1915(c) home and community based waiver service during the circuit court appeal process, the department shall reimburse for the service which occurred during the circuit court appeal process[~~remain in or continue to receive services from a nursing facility, intermediate care facility for the mentally retarded and developmentally disabled, or community-based waiver services, a vendor payment shall be authorized to reimburse the provider for services rendered during the circuit court appeal process~~].

Section 12. Special Procedures Relating to a Managed Care Participant. (1) For an adverse action toward an enrollee regarding a service that is within the scope of managed care, the requirements governing the MCO internal appeal process and the department's state fair hearing process for the enrollee shall be as established in 907 KAR 17:010.

(2) For an adverse action by the department toward an enrollee regarding a service that is not within the scope of managed care, the appeals policies and requirements established in this administrative regulation shall apply[~~Special Procedures Relating to A Managed Care Participant. (1) A Medicaid recipient shall be informed in writing of the requirements for making a complaint, filing a grievance and requesting a hearing:~~

~~(a) By the partnership in which a member is enrolled in accordance with 907 KAR 1:705; and~~

~~(b) By the managed behavioral healthcare organization in which a member is enrolled in accordance with 907 KAR 1:710.~~

~~(2) If the decision of the partnership or the managed behavioral healthcare organization is adverse to the member, the member or his authorized representative:~~

~~(a) May request a hearing regarding the action or inaction on the part of the partnership, the managed behavioral healthcare organization or its subcontracted provider to the department in accordance with Section 3 of this administrative regulation; and~~

~~(b) Shall not be required to employ or exhaust the other complaint or grievance resolution processes contained within the partnership or managed behavioral healthcare organization plan.~~

~~(3) A cabinet level appeal shall be processed as established in Sections 3, 4, 6, 7, 8, and 9 of this administrative regulation~~].

Section 13. Limitation of Fees. (1) Pursuant to KRS 205.237, the maximum fee that an attorney may charge the applicant or recipient for the representation in all categories of Medicaid shall be:

(a) Seventy-five (75) dollars for preparation and appearance at a hearing before a hearing officer;

(b) $175 for preparation and presentation, including a pleading and appearance in court, of an appeal to the circuit court; or

(c) $300 for preparatory work and briefs and all other matters

incident to an appeal to the Court of Appeals.

(2)(a) Enforcement of payment of a fee shall:

1. Not be a matter for the department or the cabinet; and

2. Be a matter between the counsel or agent and the recipient.

(b) The fee[~~shall be a matter entirely between the counsel or agent and the recipient. The fee~~] shall not be deducted from a public assistance payment otherwise due and payable to the recipient.

Section 14. A hearing or an appeal relating to a decision to reclassify or transfer a person with an intellectual disability[~~mental retardation~~] in a state institution shall be in accordance with the requirement of KRS 210.270.

Section 15. Burden of Proof. The party bearing the burden of proof shall be determined in accordance with KRS 13B.090(7).

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: April 15, 2013

FILE WITH LRC: April 16, 2013 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@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 establishes Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of authorizing statutes by establishing Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.

(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 authorizing statutes by establishing Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.

(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 replaces the reference to an obsolete agency, Department for Social Insurance, with the current hearing agency; establishes that state fair hearings requirements for managed care enrollees and managed care appeals requirements for managed care enrollees shall be as established in another administrative regulation (907 KAR 17:010, Managed care organization requirements and policies relating to enrollees); inserts definitions for clarity and clarifies policies; and contains language and formatting revisions to comply with KRS Chapter 13A as this administrative regulation has not been amended since 1993.

(b) The necessity of the amendment to this administrative regulation: The amendment regarding managed care enrollee appeals and state fair hearings is necessary as a new administrative regulation now establishes those policies and requirements; some amendments are necessary to clarify policy; some amendments are necessary to ensure that language and formatting comply with KRS Chapter 13A standards; and one amendment (replacing the agency title Department of Social Insurance with Department for Community Based Services) is necessary to correct an obsolete reference.

(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 revising language and formatting to ensure that it complies with KRS Chapter 13A standards.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statues by clarifying policy and revising language and formatting to ensure that it complies with KRS Chapter 13A standards.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation affects recipients of Medicaid services.

(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: A recipient who wishes to appeal a Medicaid service denial shall comply with the appeal provisions established in this administrative regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): DMS anticipates no cost imposed by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The clarifications should benefit recipients in being able to better understanding the appeals policies and requirements.

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

(a) Initially: DMS anticipates that the amendment to this administrative regulation will not result in additional costs to the department.

(b) On a continuing basis: DMS anticipates that the amendment to this administrative regulation will not result in additional costs to the department.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency 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: This administrative regulation does not impose or increase any fees.

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

(9) Tiering: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administration 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?

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS Chapter 13B, KRS 194A.030(2), 194A.050(1), 205.231, 205.237, 205.520(3), 42 C.F.R. 431 Subpart E and 42 C.F.R. 483 Subpart E.

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 Department for Medicaid Services (DMS) anticipates no revenue for state or local government will result from the amendment.

(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? DMS anticipates no revenue for state or local government will result from the amendment.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost as a result of the amendment.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost as a result of the amendment.

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: No additional expenditures are necessary to implement this amendment.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 431 Subpart E and 42 C.F.R. 483 Subpart E.

2. State compliance standards. 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 for the provision of medical assistance to Kentucky's indigent citizenry. KRS 194A.050(1) requires the cabinet secretary to "formulate, promote, establish, and execute policies, plans, and programs and shall adopt, administer, and enforce throughout the Commonwealth all applicable state laws and all administrative regulations necessary under applicable state laws to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth and necessary to operate the programs and fulfill the responsibilities vested in the cabinet. The secretary 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." KRS 205.237 establishes that "any individual claiming public assistance in any proceeding before the appeal board or a court may be represented by counsel; but no counsel shall either charge or receive for such service more than an amount established by the secretary by administrative regulation." KRS 205.231 establishes appeals, hearing officer and related provisions as follows: "(1) The secretary shall appoint one (1) or more impartial hearing officers to hear and decide upon appealed decisions. (2) Any applicant or recipient who is dissatisfied with the decision or delay in action on his application for public assistance or the amount granted to him may appeal to a hearing officer, except that an appeal and a hearing need not be granted if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients of the Kentucky medical assistance program so long as advance notice of the change, with an explanation of appeal rights, is provided to all affected recipients. However, a recipient may appeal whether the cabinet is accurately interpreting a change in federal or state law which may adversely affect the recipient. On receipt of an appeal, an administrative hearing shall be conducted in accordance with KRS Chapter 13B.

(3) The secretary may appoint an Appeal Board for Public Assistance composed of the secretary and two (2) other members. The secretary shall be chairman, and he and one (1) other member constitute a quorum.

(4) Any applicant or recipient who is dissatisfied with the decision of a hearing officer may appeal to the appeal board in the manner and form prescribed by administrative regulation. The board may on its own motion affirm, modify, or set aside any decision of a hearing officer on the basis of the evidence previously submitted in the case, or direct the taking of additional evidence, or may permit any of the parties to the decision to initiate further appeals before it. The board may remove itself or transfer to another hearing officer the proceedings on any appeal pending before a hearing officer. The board shall promptly notify the parties to any proceedings of its findings and decisions.

(5) The manner in which appeals are presented and hearings and appeals conducted under subsection (4) of this section shall be in accordance with administrative regulations promulgated by the secretary.

(6) After a decision by the appeal board, any party aggrieved by the decision may seek judicial review of the decision by filing a petition in the Circuit Court of the county in which the petitioner resides, in accordance with KRS 13B.140, 13B.150, and 13B.160."

3. Minimum or uniform standards contained in the federal mandate. 42 C.F.R. 431, Subpart E requires the Medicaid program's hearing system to provide for a hearing before the agency or an evidentiary hearing at the local level, with a right of appeal to a State agency hearing and the hearing system must meet the due process standards established in Goldberg v. Kelly, 397 U.S. 254 (1970), and any additional standards specified in 42 C.F.R. 431, Subpart E. Additionally, the Medicaid program must satisfy various notice requirements as well as hearing conduct requirements among other related requirements. 42 C.F.R. 483, Subpart E requires the Medicaid program to provide a system for a resident of a skilled nursing facility (SNF) or a nursing facility (NF) to appeal a notice from the SNF or NF of intent to discharge or transfer the resident, and for an individual adversely affected by any preadmission screening resident review (PASRR) determination made by the State in the context of either a preadmission screening or an annual resident review under subpart C of part 483 to appeal that determination. Additionally, the Medicaid program must provide an appeals system that meets the requirements of this 42 C.F.R. 483, Subpart E and 42 C.F.R. 431, Subpart E.

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 the stricter standard, or additional or different responsibilities or requirements. This amendment does not impose stricter, than federal, requirements.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Community Alternatives
(Amendment)

907 KAR 1:595. Model Waiver II service coverage and reimbursement policies and requirements.

RELATES TO: KRS 314.011, 42 C.F.R. 440.70, 440.185, 42 U.S.C. 1396, 42 U.S.C. 1396n(c)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1315

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 any requirement that may be imposed or opportunity

presented, to qualify for federal Medicaid funds[~~by federal law for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes the service coverage and reimbursement policies and requirements[~~provisions~~] relating to Model Waiver II services provided to a Medicaid-eligible recipient. These services are provided pursuant to a 1915(c) home and community based waiver granted by the U. S. Department for Health and Human Services in accordance with 42 U.S.C. 1396n(c).

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) "Department" means the Department for Medicaid Services or its designee.

(3) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(4) "Home health agency" means an agency that is:

(a) Licensed in accordance with 902 KAR 20:081;

(b) Medicare certified; and

(c) Medicaid certified.

(5)[~~(4)~~] "Licensed practical nurse" is defined by KRS 314.011(9).

(6)[~~(5)~~] "Model Waiver II services" means 1915(c) home and community based waiver program in-home ventilator services provided to a Medicaid-eligible recipient who:

(a) Is dependent on a ventilator; and

(b) Would otherwise require a nursing facility[~~(NF)~~] level of care in a hospital based nursing facility[~~NF~~] which will accept a recipient who is dependent on a ventilator.

(7)[~~(6)~~] "Private duty nursing agency" means a facility licensed to provide private duty nursing services:

(a) By the Cabinet for Health and Family Services, Office of Inspector General; and

(b) Pursuant to 902 KAR 20:370.

(8)[~~(7)~~] "Recipient" is defined by KRS 205.8451(9).

(9)[~~(8)~~] "Registered nurse" is defined by KRS 314.011(5).

(10)[~~(9)~~] "Registered respiratory therapist" is defined by KRS 314A.010(3)(a).

(11)[~~(10)~~] "Ventilator" means a respiration stimulating mechanism.

(12)[~~(11)~~] "Ventilator dependent" means the condition or state of an individual who:

(a) Requires the aid of a ventilator for respiratory function; and

(b) Meets the high intensity nursing facility patient status criteria established in 907 KAR 1:022[~~, Section 4~~].

Section 2. Model Waiver II Recipient Eligibility and Related Policies. (1) To be eligible to receive Model Waiver II services, an individual shall:

(a) Be eligible for Medicaid pursuant to 907 KAR 1:605;

(b) Require ventilator support for at least twelve (12) hours per day;

(c) Meet ventilator dependent patient status requirements established in 907 KAR 1:022;

(d) Submit to the department an application packet which shall contain:

1. A MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form;

2. A MAP-351A, Medicaid Waiver Assessment Form; and

3. A MAP109 -MWII, Plan of Care/Prior Authorization for Model Waiver II Services, which shall be signed and dated by a physician; and

(e) Receive notification of an admission packet approval from the department.

(2) To remain eligible for Model Waiver II services, the requirements established in this subsection shall be met.

(a) An individual shall:

1. Maintain Medicaid eligibility requirements established in 907 KAR 1:605; and

2. Remain ventilator dependent pursuant to 907 KAR 1:022.

(b) A Model Waiver II level of care determination confirming that the individual qualifies shall be performed and submitted to the department every six (6) months.

(c) A MAP 109, Plan of Care/Prior Authorization for Model Waiver II Services shall be:

1. Signed and dated by a physician every sixty (60) days on behalf of the individual; and

2. Submitted to the department, after being signed and dated in accordance with subparagraph 1 of this paragraph, every sixty (60) days.

(3) A Model Waiver II service shall not be provided to a recipient who is:

(a) Receiving a service in another 1915(c) home and community based waiver program; or

(b) An inpatient of:

1. A nursing facility;

2. An intermediate care facility for individuals with an intellectual[~~mental retardation or a developmental~~] disability; or

3. Another facility.

(4) The department shall not authorize a Model Waiver II service unless it has ensured that:

(a) Ventilator dependent status has been met;

(b) The service:

1. Is available to the recipient;

2. Will meet the need of the recipient; and

3. Does not exceed the cost of traditional institutional ventilator care.

Section 3. Provider Participation Requirements. To participate in the Model Waiver II program, a:

(1) Home health agency[~~or private duty nursing agency~~] shall:

(a)[~~(1)~~] Be a currently participating Medicaid provider in accordance with 907 KAR 1:671;

(b)[~~(2)~~] Be currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and

(c)[~~(3)~~] Meet the home and community based waiver service provider requirements established in 907 KAR 1:160; or

(2) Private duty nursing agency shall:

(a) Be a currently participating Medicaid provider in accordance with 907 KAR 1:671;

(b) Be currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and

(c) Be a licensed private duty nursing agency in accordance with 902 KAR 20:370.

Section 4. Covered Services. (1) The following shall be covered Model Waiver II services:

(a) Skilled nursing provided by:

1. A registered nurse; or

2. A licensed practical nurse; or

(b) Respiratory therapy.

(2) Model Waiver II services shall be provided by an individual employed by or under contract through a private duty nursing agency or home health agency as a:

(a) Registered nurse;

(b) Licensed practical nurse; or

(c) Registered respiratory therapist.

Section 5. Payment for Services. The department shall reimburse a participating home health agency or private duty nursing agency for the provision of covered Model Waiver II services as established in this section.

(1) Reimbursement shall be based on a fixed fee for a unit of service provided for each covered service referenced in Section 4 of this administrative regulation with one (1) hour equal to one (1) unit of service.

(2) The fixed fee for skilled nursing services provided by:

(a) A registered nurse shall be thirty-one (31) dollars and ninety-eight (98) cents for each unit of service;

(b) A licensed practical nurse shall be twenty-nine (29) dollars and ten (10) cents for each unit of service; and

(c) A registered respiratory therapist shall be twenty-seven (27) dollars and forty-two (42) cents for each unit of service.

(3) Reimbursement shall not exceed sixteen (16) units of service per day.

(4) Payment shall not be made for a service to an individual for whom it can reasonably be expected that the cost of the 1915(c)

home and community based waiver program service furnished under this administrative regulation would exceed the cost of the service if provided in a hospital-based nursing facility[~~NF~~].

Section 6. Maintenance of Records. (1) A Model Waiver II service provider shall maintain:

(a) A clinical record for each HCB recipient which shall contain the following:

1. Pertinent medical, nursing, and social history;

2. A comprehensive assessment entered on a MAP-351A, Medicaid Waiver Assessment Form, and signed by the:

a. Assessment team; and

b. Department;

3. A completed MAP109 -MWII, Plan of Care/Prior Authorization for Model Waiver II Services;

4. A copy of the MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form signed by the recipient or the recipient's legal representative at the time of application or reapplication and each recertification thereafter;

5. Documentation of all level of care determinations;

6. All documentation related to prior authorizations including requests, approvals, and denials;

7. Documentation that the recipient or legal representative was informed of the procedure for reporting complaints; and

8. Documentation of each service provided that shall include:

a. The date the service was provided;

b. The duration of the service;

c. The arrival and departure time of the provider, excluding travel time, if the service was provided at the recipient's home;

d. Progress notes which shall include documentation of changes, responses, and treatments utilized to evaluate the recipient's needs; and

e. The signature of the service provider; and

(b) Incident reports as required by Section 7 of this administrative regulation if an incident with the recipient occurs.

(2)(a) Except as provided in paragraph (b) of this subsection, a clinical record or incident report shall be retained for at least six (6) years from the date that a covered service is provided.

(b) If the recipient is a minor, a clinical record or incident report shall be retained for three (3) years after the recipient reaches the age of majority under state law, if that is a longer time period than the time period required by paragraph (a) of this subsection.

(3) Upon request, a provider shall make information regarding service and financial records available to the:

(a) Department;

(b) Cabinet for Health and Family Services, Office of Inspector General or its designee;

(c) United States Department for Health and Human Services or its designee;

(d) General Accounting Office or its designee;

(e) Office of the Auditor of Public Accounts or its designee; or

(f) Office of the Attorney General or its designee.

Section 7. Incident Reporting. A Model Waiver II service provider shall:

(1) Implement a procedure or procedures to ensure that the following is reported:

(a) Abuse, neglect, or exploitation of a Model Waiver II recipient in accordance with KRS Chapters 209 or 620;

(b) A slip or fall;

(c) A transportation incident;

(d) Improper administration of medication;

(e) A medical complication; or

(f) An incident caused by the recipient, including:

1. Verbal or physical abuse of staff or other recipients;

2. Destruction or damage of property; or

3. Recipient self-abuse;

(2) Ensure that a copy of each incident reported in this subsection is maintained in a central file subject to review by the department; and

(3) Implement a process for communicating the incident, the outcome, and the prevention plan to:

(a)[~~1.~~] The Model Waiver II service recipient involved, his or her family member, or his or her responsible party; and

(b)[~~2.~~] The attending physician, physician assistant, or advanced practice registered nurse.

Section 8. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A Model Waiver II service provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, and contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature immediately upon request.

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 federal financial participation for the policy; or

(2) Disapproves the policy.

Section 10. Appeal Rights. (1) An appeal of a negative action regarding a Medicaid recipient shall be appealed in accordance with 907 KAR 1:563.

(2) An appeal of a negative action regarding a Medicaid beneficiary's eligibility shall be appealed in accordance with 907 KAR 1:560.

(3) An appeal of a negative action regarding a Medicaid provider shall be appealed in accordance with 907 KAR 1:671.

Section 11[~~10~~]. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) [~~A~~] "MAP109 -MWII, Plan of Care/Prior Authorization for Model Waiver II Services", April 2004 edition;

(b) [~~A~~] "MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form", January 2000 edition; and

(c) [~~A~~] "MAP-351A, Medicaid Waiver Assessment Form", June 15, 2002 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.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: May 13, 2013

FILED WITH LRC: May 13, 2013 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Karen Martin, Ellenore Callan, or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the service coverage and reimbursement policies for the Medicaid Model Waiver II services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the service coverage and reimbursement policies for the Medicaid Model Waiver II services.

(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 service coverage and reimbursement policies for the Medicaid Model Waiver II 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 service coverage and reimbursement policies for the Medicaid Model Waiver II services.

(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 eliminates the requirement that a private duty nursing agency must meet home and community based waiver provider requirements in order to provide Model Waiver II services.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to enable private duty nursing agencies to provide Model Waiver II services as the demand exceeds the availability of providers.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by ensuring that Medicaid recipients in need of Model Waiver II services have access to the services.

(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 ensuring that Medicaid recipients in need of Model Waiver II services have access to the services.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Model Waiver II service recipients will be affected by the amendment and private duty nursing agencies who wish to provide Model Waiver II services will be affected by the amendment. As of March 1, 2013, there were approximately fifty (50) individuals receiving Model Waiver II services. The Department for Medicaid Services (DMS) anticipates that at least three (3) private duty nursing agencies will be able to provide Model Waiver II services as independent providers.

(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: A private duty nursing agency which wishes to become a Model Waiver II service provider will have to enroll as a Medicaid provider.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Private duty nursing agencies wishing to provide Model Waiver II services may experience some administrative cost associated with becoming a provider.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Private duty nursing agencies who become Model Waiver II service providers will be able to be reimbursed by DMS for providing services. Model Waiver II service recipients will be expected to benefit by the increased number of Model Waiver II service providers available to provide services.

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

(a) Initially: DMS anticipates that the net result will not increase cost because some home and community based waiver providers have been subcontracting with private duty nursing agencies. Additionally, individuals who might be unable to receive Model Waiver II services, due to lack of access to providers, could have to be admitted to a nursing facility or intermediate care facility for individuals with an intellectual disability (ICF IID.) Model Waiver II services cost less than institutional care; thus, authorizing private duty nursing agencies to provide Model Waiver II services helps prevent DMS from experiencing more institutional care cost.

(b) On a continuing basis: DMS anticipates that the net result will not increase cost because some home and community based waiver providers have been subcontracting with private duty nursing agencies. Additionally, individuals who might be unable to receive Model Waiver II services, due to lack of access to providers, could have to be admitted to a nursing facility or intermediate care facility for individuals with an intellectual disability (ICF IID.) Model Waiver II services cost less than institutional care; thus, authorizing private duty nursing agencies to provide Model Waiver II services helps prevent DMS from experiencing more institutional care cost.

(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 of general 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 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 increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Model Waiver II services are not federally mandated.

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. Model Waiver II services are not federally mandated.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal 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.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 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? 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 net result will not increase cost because some home and community based waiver providers have been subcontracting with private duty nursing agencies. Additionally, individuals who might be unable to receive Model Waiver II services, due to lack of access to providers, could have to be admitted to a nursing facility or intermediate care facility for individuals with an intellectual disability (ICF IID.) Model Waiver II services cost less than institutional care; thus, authorizing private duty nursing agencies to provide Model Waiver II services helps prevent DMS from experiencing more institutional care cost.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates that the net result will not increase cost because some home and community based waiver providers have been subcontracting with private duty nursing agencies. Additionally, individuals who might be unable to receive Model Waiver II services, due to lack of access to providers, could have to be admitted to a nursing facility or intermediate care facility for individuals with an intellectual disability (ICF IID.) Model Waiver II services cost less than institutional care; thus, authorizing private duty nursing agencies to provide Model Waiver II services helps prevent DMS from experiencing more institutional care cost.

NEW ADMINISTRATIVE REGULATIONS

CABINET FOR HEALTH AND FAMILY SERVICES
Office of the Kentucky Health Benefit Exchange
(New Administrative Regulation)

900 KAR 10:010. Exchange Participation Requirements and Certification of Qualified Health Plans and Qualified Dental Plans.

RELATES TO: KRS 194A.050(1), 42 U.S.C. 18031, 45 C.F.R. Parts 155, 156

STATUTORY AUTHORITY: KRS 194A.050(1)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Office of the Kentucky Health Benefit Exchange, has responsibility to administer the state-based American Health Benefit Exchange. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet; and to implement programs mandated by federal law or to qualify for the receipt of federal funds. This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan to be offered on the Kentucky Health Benefit Exchange, pursuant to and in accordance with 42 U.S.C. 18031 and 45 C.F.R. Parts 155 and 156.

Section 1. Definitions. (1) "Actuarial value" means the percentage of the total allowed costs of benefits paid by a health plan.

(2) "Affordable Care Act" or "ACA" means the Patient Protection and Affordable Care Act, Public Law 111-148, enacted March 23, 2010 as amended by the Health Care and Education Reconciliation Act, Public Law 111-152, enacted March 30, 2010.

(3) "Agent" is defined by KRS 304.9-020(1).

(4) "Annual open enrollment period" except for the initial open enrollment period, is defined by 45 C.F.R. 155.410(e).

(5) "Benefit year" means a calendar year for which a health plan provides coverage for health benefits.

(6) "Catastrophic plan" means a health plan that is described in and meets the requirements of 45 C.F.R 156.155.

(7) "Certificate of authority" is defined by KRS 304.1-110.

(8) "Certification" means a determination by the Kentucky Health Benefit Exchange that a health plan or a stand-alone dental plan has met the requirements in Sections 2 through 17 of this administrative regulation.

(9) "Child-only plan" means an individual health policy that provides coverage to an individual under twenty-one (21) years of age and meets the requirements of 45 C.F.R 156.200(c)(2).

(10) "Consumer Operated and Oriented Plan" or "CO-OP" means a private, non-profit health insurance issuer established in Section 1322 of the Affordable Care Act that has a certificate of authority.

(11) "Dental Insurer" means an insurer defined by KRS 304.17C-010(4), which offers a limited health service benefit plan for dental services.

(12) "Department of Health and Human Services" or "HHS" means the U.S. Department of Health and Human Services.

(13) "Department of Insurance" or "DOI" is defined by KRS 304.1-050(2).

(14) "Enrollee" means an eligible individual enrolled in a qualified health plan.

(15) "Essential community provider" means a provider determined and approved by HHS as an essential community provider for the Commonwealth of Kentucky.

(16) "Essential community provider category" means a provider as described in "Chapter 7: Instructions for the Essential Community Providers Application Section", as incorporated by reference in this administrative regulation.

(17) "Essential health benefits" means benefits as identified by 42 U.S.C. 18022 and approved by the Secretary of HHS for the Commonwealth of Kentucky.

(18) "Health plan" is defined by 42 U.S.C. 18021(b)(1).

(19) "Indian" is defined by 25 U.S.C. 450b(d).

(20) "Issuer" is defined by 45 C.F.R. 144.103.

(21) "Health plan form" or "form" is defined by 806 KAR 14:007.

(22) "Individual exchange" means the Kentucky Health Benefit Exchange that serves the individual health insurance market.

(23) "Individual market" is defined by KRS 304.17A-005(26).

(24) "Initial open enrollment period" means the period beginning October 1, 2013, and extending through March 31, 2014, during which a qualified individual or qualified employee may enroll in health coverage through an exchange for the 2014 benefit year.

(25) "Kentucky Health Benefit Exchange" or "KHBE" means the Kentucky state-based exchange conditionally approved by HHS pursuant to 45 C.F.R. 155.105 to offer a QHP beginning January 1, 2014.

(26) "Metal level of coverage" means health care coverage provided within plus or minus two (2) percentage points of the full actuarial value as follows:

(a) Bronze level with an actuarial value of 60 percent;

(b) Silver level with an actuarial value of 70 percent;

(c) Gold level with an actuarial value of 80 percent; and

(d) Platinum level with an actuarial value of 90 percent.

(27) "Multi-state plan" means a health plan that is offered under a contract with the U.S. Office of Personnel Management in accordance with Section 1334 of the Affordable Care Act.

(28) "Office of the Kentucky Health Benefit Exchange" or "Office" means the office created to administer the Kentucky Health Benefit Exchange.

(29) "Participating agent" means an agent as defined by KRS 304.9-020(1) who has been certified by the office to participate on the KHBE.

(30) "Participation agreement" means an agreement between the office and the issuer to offer a QHP or qualified dental plan on the KHBE.

(31) "Pediatric dental essential health benefit" means a dental service to prevent disease and promote oral health, restore an oral structure to health and function, and treat an emergency condition provided to an individual under the age of twenty-one (21) years that meets the requirements of 45 C.F.R. 156.110(a)(10).

(32) "Plan management data template" means the data collection templates used to facilitate data submission for certification of qualified health plan issuers and qualified health plans as established in CMS Form Number CMS-10433, as amended.

(33) "Plan year" means a consecutive twelve (12) month period during which a health plan provides coverage for health benefits.

(34) "Premium" is defined by KRS 304.14-030.

(35) "Provider network" is defined by KRS 304.17A-005(35).

(36) "Qualified dental plan" means a dental plan certified by the KHBE that provides a limited scope of dental benefits as defined in 26 U.S.C. 9832(c)(2)(A), limited to a pediatric dental essential health benefit which complies with the requirements of 45 C.F.R. 156.110(a)(10).

(37) "Qualified employee" means an individual employed by a qualified employer who has been offered health insurance coverage by the qualified employer through the SHOP.

(38) "Qualified employer" means an employer that elects to make, at a minimum, all full-time employees of the employer eligible for one (1) or more QHPs in the small group market offered through the SHOP.

(39) "Qualified health plan" or "QHP" means a health plan that meets the standards described in 45 C.F.R. 156 Subpart C and that has in effect a certification issued by the KHBE.

(40) "Qualified individual" means an individual who has been determined eligible to enroll through the KHBE in a QHP in the individual market.

(41) "Service area" means a geographical area in which an issuer may offer a QHP.

(42) "SHOP" means a Small Business Health Options Program operated by the KHBE through which a qualified employer can provide a qualified employee and their dependents with access to one (1) or more QHPs.

(43) "Small group" is defined by KRS 304.17A-005(42).

(44) "Stand-alone dental plan" means a dental plan as described by 45 C.F.R. 155.1065.

(45) "Summary of Benefits and Coverage" or "SBC" means a standard format, created in accordance with 42 U.S.C. 300gg-15, for providing information to consumers about a health plan's coverage and benefits.

(46) "System for Electronic Rate and Form Filing" or "SERFF" means an online system established and maintained by the National Association of Insurance Commissioners (NAIC) that enables an issuer to send and a state to receive, comment on, and approve or reject rate and form filings.

Section 2. QHP Issuer General Requirements. In order for an issuer to participate in the KHBE beginning January 1, 2014, the issuer shall:

(1) Hold a certificate of authority and be in good standing with the Kentucky Department of Insurance;

(2) Be authorized by the office to participate on the KHBE;

(3) Enter into a participation agreement with the KHBE;

(4) Offer KHBE certified QHPs in the individual exchange or the SHOP exchange;

(5) Comply with benefit design standards as established in 45 C.F.R. 156.20;

(6) Provide coverage of the;

(a) Essential health benefits; or

(b) If stand-alone pediatric dental essential health benefit is offered in the KHBE in accordance with 45 C.F.R 155.1065, essential health benefits excluding pediatric dental essential health benefits;

(7) Implement and report on a quality improvement strategy or strategies consistent with the standards of 42 U.S.C. 18031(g);

(8) Comply with applicable standards described in 45 C.F.R. Part 153;

(9) For the individual exchange, offer at least a:

(a) QHP with a silver metal level of coverage;

(b) QHP with a gold metal level of coverage;

(c) Child-only plan; and

(d) Catastrophic plan.

(10) For the SHOP exchange, offer at least a:

(a) QHP with a silver metal level of coverage; and

(b) QHP with a gold metal level of coverage;

(11) For the individual and SHOP exchange, offer no more than four (4) QHPs within a specified metal level of coverage. For the purposes of establishing the number of QHPs offered in a metal level, the KHBE shall consider the same plan offered with dental benefits and offered without dental benefits as one (1) QHP;

(12) Not discriminate, with respect to a QHP, on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation;

(13) Assure that the non-discrimination requirements in 42 U.S.C. 300gg-5 are met;

(14) If participating in the small group market, comply with KHBE processes, procedures, and requirements established in accordance with 42 C.F.R. 155.705 for the small group market;

(15) Allow a participating agent to:

(a) Enroll individuals, employers, and employees in QHPs offered on the exchange;

(b) Enroll qualified individuals in a QHP in a manner that constitutes enrollment through the KHBE; and

(c) Assist individuals in applying for advance payments of premium tax credit and cost sharing reductions; and

(16)(a) Offer a QHP in a statewide service area, except as allowed under paragraph (b) of this subsection; or

(b) Offer a QHP in a service area less than statewide if:

1. A QHP is available statewide;

2. The issuer's service area includes one (1) or more counties;

3. The issuer's service area is approved by the DOI; and

4. The issuer's service area is established in a nondiscriminatory manner without regard to:

a. Race;

b. Ethnicity;

c. Language;

d. Health status of an individual in a service area; or

e. A factor that excludes a high utilizing, high cost or medically-underserved population.

Section 3. QHP Rate and Benefit Information. (1) A QHP issuer shall:

(a) Comply with the provisions of 45 C.F.R. 156.210 and KRS 304.17A-095(4);

(b) Submit to DOI through the SERFF system:

1. Form filings in compliance with KRS 304.14-120 and applicable administrative regulations promulgated thereunder;

2. Rate filings in compliance with KRS 304.17A-095 and applicable administrative regulations promulgated thereunder;

3. Plan management data templates;

(c) Receive approval from DOI for a rate filing prior to implementation of the approved rate; and

(d) For a rate increase, post the justification prominently on the QHP issuer's Web site.

(2) A CO-OP, multi-state plan, and qualified dental plan shall comply with requirements identified by subsection (1) of this section.

Section 4. QHP Certification and Recertification Timeframes. (1) The KHBE will take final action on the request for certification or recertification of QHPs no later than August 31 for the following plan year.

(2) A QHP not certified or recertified by August 31 may not be offered on the exchange at any time during the following calendar year.

Section 5. Transparency in Coverage. (1) A QHP issuer shall provide the following information to the office in accordance with the standards established by subsection (2) of this section:

(a) Claims payment policies and practices;

(b) Periodic financial disclosures;

(c) Data on enrollment;

(d) Data on disenrollment;

(e) Data on the number of denied claims;

(f) Data on rating practices;

(g) SBC;

(h) Information on cost-sharing and payments for out-of-network coverage; and

(i) Information on enrollee rights under Title I of the Affordable Care Act.

(2) A QHP issuer shall:

(a) Submit, in an accurate and timely manner, to be determined by HHS, the information described in subsection (1) of this section to the KHBE, HHS, and DOI; and

(b) Provide public access to the information described in subsection (1) of this section.

(3) A QHP issuer shall ensure that the information submitted under subsection (1) of this section is provided in plain language as the term is defined by 45 C.F.R. 155.20.

(4)(a) A QHP issuer shall make available, in a timely manner, information about the amount of enrollee cost-sharing under the enrollee's plan or coverage relating to provision of a specific item or service by a participating provider upon the request of the enrollee.

(b) The information shall be made available to an enrollee through:

1. An Internet Web site; and

2. Other means if the enrollee does not have access to the Internet.

Section 6. Marketing and Benefit Design of QHPs. A QHP issuer and its officials, employees, agents, and representatives shall:

(1) Comply with issuer marketing practices provided under KRS 304.17A and 806 KAR 12:010; and

(2) Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with complex health care needs in QHPs.

Section 7. Network Adequacy Standards. (1) A QHP issuer shall ensure that the provider network of a QHP is available to all

enrollees within the QHP service area, and:

(a) Includes essential community providers in the QHP provider network in accordance with 45 C.F.R. 156.235 and meets the network adequacy standards for essential community providers as established in Section 8 of this administrative regulation;

(b) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be provided in a timely manner; and

(c) Meets the reasonable network adequacy provisions of 45 C.F.R. 156.230 and KRS 304.17A-515.

(2) A QHP issuer shall make its provider directory for a QHP available:

(a) To the KHBE for online publication;

(b) To potential enrollees in hard copy upon request; and

(c) In accordance with KRS 304.17A-590.

(3) A QHP issuer shall identify in the QHP provider directory a provider that is not accepting new patients.

Section 8. Network Adequacy Standards for Essential Community Providers for Coverage Year 2014. A QHP issuer shall:

(1)(a) Demonstrate a provider network, which includes at least twenty (20) percent of available essential community providers in the QHP service area participate in the issuers provider network; and

(b) Offer a contract to:

1. At least one (1) essential community provider in each essential community provider category in each county in the service area where an essential community provider in that category is available; and

2. Available Indian providers in the service area, using the Model Indian Addendum as developed by The Centers for Medicare and Medicaid Services and identified in the "Supplementary Response: Inclusion of Essential Community Providers" form incorporated by reference in this administrative regulation; or

(2) If unable to comply with the requirements in subsection (1) of this section:

(a) Demonstrate a provider network which includes at least ten (10) percent of available essential community providers in the QHP service area; and

(b) Submit a supplementary response as identified in "Supplementary Response: Inclusion of Essential Community Providers" as incorporated by reference in this administrative regulation.

Section 9. Health Plan Applications and Notices. A QHP issuer shall provide an application, including the streamlined application designated by the office, and notices to enrollees pursuant to standards described in 45 C.F.R. 155.230.

Section 10. Consistency of Premium Rates Inside and Outside the KHBE for the Same QHP. A QHP issuer shall charge the same premium rate without regard to whether the plan is offered:

(1) Through the KHBE;

(2) By an issuer outside the KHBE; or

(3) Through a participating agent.

Section 11. Enrollment Periods for Qualified Individuals. (1) A QHP issuer participating in the individual market shall:

(a) Enroll a qualified individual during the initial and annual open enrollment periods described in 45 C.F.R 155.410(b) and (e) and comply with the effective dates of coverage established by the KHBE in accordance with 45 C.F.R. 155.410(c)(1) and (f); and

(b) Make available, at a minimum, special enrollment periods described in 45 C.F.R. 155.420(d), for QHPs and comply with the effective dates of coverage established by the KHBE in accordance with 45 C.F.R 155.420(b).

(2) A QHP issuer shall notify a qualified individual of the effective date of coverage.

(3) Notwithstanding the requirements of this section, coverage shall not be effective until premium payment is submitted by the individual.

Section 12. Enrollment Process for Qualified Individuals. (1) A QHP issuer shall process enrollment of an individual in accordance with this section.

(2) A QHP issuer participating in the individual market shall enroll a qualified individual if the KHBE:

(a) Notifies the QHP issuer that the individual is a qualified individual; and

(b) Transmits information to the QHP issuer in accordance with 45 C.F.R. 155.400(a).

(3) If an applicant initiates enrollment directly with the QHP issuer for enrollment in a plan offered through the KHBE, the QHP issuer shall either:

(a) Direct the individual to file an application with the KHBE in accordance with 45 C.F.R. 155.310; or

(b) Ensure the applicant received an eligibility determination for coverage through the KHBE through the KHBE Internet Web site.

(4) A QHP issuer shall accept enrollment information in accordance with the privacy and security requirements established by the KHBE pursuant to 45 C.F.R. 155.260 and in an electronic format pursuant to with 45 C.F.R. 155.270.

(5) A QHP issuer shall follow the premium payment process established by the KHBE in accordance with 45 C.F.R. 155.240.

(6) A QHP issuer shall provide new enrollees with an enrollment information package that complies with the accessibility and readability requirements established by 45 C.F.R. 155.230(b).

(7) A QHP issuer shall reconcile enrollment files with the KHBE no less than once a month in accordance with 45 C.F.R. 155.400(d).

(8) A QHP issuer shall acknowledge receipt of enrollment information transmitted from the KHBE in accordance with KHBE requirements established by 45 C.F.R. 155.400(b)(2).

Section 13. Termination of Coverage for Qualified Individuals. (1) A QHP issuer may terminate coverage of an enrollee in accordance with 45 C.F.R. 155.430(b)(2).

(2) If an enrollee's coverage in a QHP is terminated for any reason, the QHP issuer shall:

(a) Provide the enrollee with a notice of termination of coverage that includes the reason for termination at least thirty (30) days prior to the final day of coverage, in accordance with the effective date established pursuant to 45 C.F.R. 155.430(d);

(b) Notify the KHBE of the termination effective date and reason for termination; and

(c) Comply with the requirements of KRS 304.17A-240 to 304.17A-245.

(3) Termination of coverage of enrollees due to non-payment of premium in accordance with 45 C.F.R. 155.430(b)(2)(ii) shall:

(a) Include the grace period for enrollees receiving advance payments of the premium tax credits as described in 45 C.F.R. 156.270 (d); and

(b) Be applied uniformly to enrollees in similar circumstances.

(4) A QHP issuer shall provide a grace period of three (3) consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one (1) full month's premium during the benefit year. During the grace period, the QHP issuer:

(a) 1. Shall pay claims for services provided to the enrollee in the first month of the grace period; and

2. May suspend payment of claims for services provided to the enrollee in the second and third months of the grace period;

(b) Shall notify HHS of the non-payment of the premium due; and

(c) Shall notify providers of the possibility for denied claims for services provided to an enrollee in the second and third months of the grace period.

(5) For the three (3) months grace period described in subsection (4) of this section, a QHP issuer shall:

(a) Continue to collect advance payments of the premium tax credit on behalf of the enrollee from the U.S. Department of the Treasury; and

(b) Return advance payments of the premium tax credit paid on behalf of the enrollee for the second and third months of the grace period if the enrollee exhausts the grace period as described in subsection (7) of this section.

(6) If an enrollee is delinquent on premium payment, the QHP issuer shall provide the enrollee with a notice of the payment delin-

quency.

(7) If an enrollee receiving advance payments of the premium tax credit exhausts the three (3) months grace period in subsection (4) of this section without paying the outstanding premiums, the QHP issuer shall terminate the enrollee's coverage on the effective date of termination described in 45 C.F.R. 155.430(d)(4) if the QHP issuer meets the notice requirement specified in subsection (2) of this section.

(8) A QHP issuer shall maintain records in accordance with KHBE requirements established pursuant to 45 C.F.R. 155.430(c).

(9) A QHP issuer shall comply with the termination of coverage effective dates as described in 45 C.F.R. 155.430(d).

Section 14. Accreditation of QHP Issuers. (1) A QHP issuer shall:

(a) Be accredited on the basis of local performance of a QHP by an accrediting entity recognized by HHS in categories identified by 45 C.F.R. 156.275(a)(1); and

(b) Pursuant to 45 C.F.R. 156.275(a)(2) authorize the accrediting entity that accredits the QHP issuer to release to the KHBE and HHS:

1. A copy of the most recent accreditation survey; and

2. Accreditation survey-related information that HHS may require, including corrective action plans and summaries of findings.

(2) A QHP issuer shall be accredited within three (3) years of initial QHP certification in accordance with requirements identified by 45 C.F.R. 155.1045.

(3) The QHP issuer shall maintain accreditation so long as the QHP issuer offers QHPs.

Section 15. Recertification, Non-renewal, and Decertification of QHPs. (1) A QHP shall be recertified in accordance with the requirements of this administrative regulation every two (2) years no later than August 31 for the following plan year.

(2) An issuer shall submit to the exchange a request for recertification of a QHP at least ninety (90) days prior to an expiration of a certification.

(3) If a QHP issuer elects not to seek recertification with the KHBE, the QHP issuer, at a minimum, shall:

(a) Notify the KHBE of its decision prior to the beginning of the recertification process and follow the procedures adopted by the KHBE in accordance with 45 C.F.R. 155.1075;

(b) Provide benefits for enrollees through the final day of the plan or benefit year;

(c) Submit reports as required by the KHBE for the final plan or benefit year of the certification;

(d) Provide notices to enrollees in accordance with Section 13 of this administrative regulation;

(e) Terminate coverage of enrollees in the QHP in accordance with 45 C.F.R. 156.270, as applicable; and

(f) Comply with requirements of KRS 304.17A-240 and 304.17A-245.

(4) If a QHP is decertified by the KHBE pursuant to 45 C.F.R. 155.1080, the QHP issuer shall terminate coverage of enrollees only after:

(a) The KHBE has provided notification as required by 45 C.F.R 155.1080(e);

(b) Enrollees have an opportunity to enroll in other coverage; and

(c) The QHP issuer has complied with the requirements of KRS 304.17A-240 and 304.17A-245.

Section 16. General Requirements for a Stand-alone Dental Plan. (1) In order for a dental insurer to participate in the KHBE beginning January 1, 2014 and offer a stand-alone dental plan, the dental insurer shall:

(a) Hold a certificate of authority to offer dental plans and be in good standing with the Kentucky Department of Insurance;

(b) Be authorized by the office to participate on the KHBE;

(c) Enter into a participation agreement with the KHBE;

(d) Offer a pediatric dental plan certified by the KHBE in accordance with this administrative regulation in the individual exchange or SHOP exchange that shall:

1. Comply with the requirements of KRS Chapter 304 Subtitle17C;

2. Submit to DOI through the SERFF system:

a. Form and rate filings in compliance with KRS Chapter 304; and

b. Dental plan management data templates;

(e) Offer a stand-alone dental plan that shall:

1. Be limited to a pediatric dental essential health benefit required by 42 U.S.C. 18022(b)(J) for individuals up to twenty-one (21) years of age;

2. Pursuant to 45 C.F.R. 156.150, provide within a variation of plus or minus two (2) percentage points:

a. A low level of coverage with an actuarial value of seventy (70) percent; and

b. A high level of coverage with an actuarial value of eighty five (85) percent; and

3. Have an annual limitation on cost-sharing at or below:

a. $1,000 for a plan with one (1) child enrollee; or

b. $2,000 for a plan with two (2) or more child enrollees;

(f) Comply with the:

1. Provider network adequacy requirements identified by KRS 304.17C-040 and maintain a network that is sufficient in number and types of dental providers to assure that all dental services will be accessible without unreasonable delay in accordance with 45 C.F.R. 156.230;

2. Requirements for stand-alone dental plans referenced in 45 C.F.R. 156 Subpart E; and

3. Essential community provider requirement in 45 C.F.R. 156.235; and

(g) Not discriminate, with respect to a pediatric dental plan, on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

(2) The dental insurer offering a stand-alone dental plan participating in the KHBE beginning January 1, 2014:

(a) May offer a stand-alone dental plan which includes coverage for individuals regardless of age which includes at a minimum a pediatric dental essential health benefit required by 42 U.S.C. 18022(b)(J) coverage for individuals up to twenty-one (21) years of age; and

(b) If electing to offer the plan specified in paragraph (a) of this subsection, shall comply with the requirements of subsection (1) of this section.

Section 17. Essential health benefits for individuals up to twenty-one (21) years of age. The KHBE shall ensure that an individual up to age twenty-one (21) years of age eligible to enroll in a QHP shall obtain coverage for pediatric dental coverage.

Section 18. Enforcement. The DOI shall be responsible for enforcing the requirements of KRS Chapter 304 and any administrative regulations promulgated thereunder against any issuer.

Section 19. Issuer Appeals. (1) An issuer may appeal the office's decision to:

(a) Deny certification of a QHP;

(b) Deny recertification of a QHP; or

(c) Decertify a QHP.

(2) An issuer appeal identified in subsection (1) of this section shall be made to the office in accordance with KRS Chapter 13B.

Section 20. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Chapter 7: Instructions for the Essential Community Providers Application Section", April 2013 version; and

(b) "Supplementary Response: Inclusion of Essential Community Providers", April 2013 version.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of the Kentucky Health Benefit Exchange, 12 Mill Creek Park, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or from its Web site at www.healthbenefitexchange.ky.gov.

CARRIE BANAHAN, Executive Director
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: May 10, 2013

FILED WITH LRC: May 13, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, 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: Carrie Banahan

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the criteria for certification as a qualified health plan or a qualified dental plan to be offered on the Kentucky Health Benefit Exchange as required by 45 C.F.R. Parts 155 and 156.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to inform issuers of the requirements for certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary so that issuers are aware of the requirements for certification of a health plan as a qualified health plan or dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange as required by 45 C.F.R. Parts 155 and 156.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed requirements for certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange to comply with the 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 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 governments affected by this administrative regulation: This administrative regulation will affect approximately 15 issuers that may request certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange.

(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 submit information electronically through the SERFF system related to rate and form filings to the Department of Insurance for review by DOI and KHBE.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): $1,000.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This administrative regulation will benefit each issuer that may request certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit by providing detailed instructions regarding certification of Qualified Health Plans.

(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.

(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 Kentucky Office of Health Benefit Exchange 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 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 the Kentucky Health Benefit Exchange 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 194A.050(1), 42 U.S.C. § 18031, and 45 C.F.R. Parts 155 and 156.

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:

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. Section 18031 and 45 C.F.R. Parts 155 and 156.

2. State compliance standards. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet, and to implement programs mandated by federal law or to qualify for the receipt of federal funds. This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan to be offered on the Kentucky Health Benefit Exchange, pursuant to, and in accordance with 42 U.S.C. Section 18031 and 45 C.F.R. Parts 155 and 156.

3. Minimum or uniform standards contained in the federal mandate. The Affordable Care Act establishes the creation of the American Health Benefit Exchange as identified in Section 1311(a) of the Affordable Care Act. The "Kentucky Health Benefit Exchange" (KHBE) is the Kentucky state-based exchange conditionally approved by HHS established by 45 C.F.R. 155.105 to offer a QHP in Kentucky beginning January 1, 2014. An Exchange must make qualified health plans available to qualified individuals and qualified employers. At a minimum, an Exchange must implement procedures for the certification, recertification, and decertification of health plans as qualified health plans. The Affordable Care Act allows for Exchanges to certify health plans as qualified health plans. This certification may be done if: the health plan meets the rules for certification by the U. S. Department of Health and Human Services; and the Exchange determines that making such health plan available through the Exchange is in the interests of qualified individuals and qualified employers in the state or states in which the Exchange operates. The Exchange must require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. These plans must prominently post such information on their websites.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose stricter requirements than those required by the federal mandate.

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

907 KAR 1:071. Repeal of 907 KAR 1:070, 907 KAR 1:072, 907 KAR 1:090, 907 KAR 1:092, and 907 KAR 1:320.

RELATES TO: 42 U.S.C. 1396a

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

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 1:070, 907 KAR 1:072, 907 KAR 1:090, 907 KAR 1:092, and 907 KAR 1:320. 907 KAR 1:070, 907 KAR 1:072, 907 KAR 1:090, 907 KAR 1:092, and 907 KAR 1:320 are being repealed as the programs addressed in the respective administrative regulations no longer exist.

Section 1. The following administrative regulations are hereby repealed:

(1) 907 KAR 1:070, Homecare waiver services;

(2) 907 KAR 1:072, Payments for homecare waiver services;

(3) 907 KAR 1:090, Personal care assistance waiver services;

(4) 907 KAR 1:092, Payments for personal care assistance waiver services; and

(5) 907 KAR 1:320, Kentucky Patient Access and Care System (KenPAC).

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: May 13, 2013

FILED WITH LRC: May 13, 2013 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the Cabinet for Health and Family Services, Office of the Ombudsman's Conference Room Located on the First Floor at 1E-B; 275 East Main Street; Frankfort, Kentucky; 40621. Individuals interested in attending this hearing shall notify this agency in writing by June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@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, in accordance with KRS 13A.310(3)(c), repeals 907 KAR 1:070, Homecare waiver services; 907 KAR 1:072, Payments for homecare waiver services; 907 KAR 1:090, Personal care assistance waiver services; 907 KAR 1:092, Payments for personal care assistance waiver services; and 907 KAR 1:320, Kentucky Patient Access and Care System (KenPAC).

(b) The necessity of this administrative regulation: 907 KAR 1:070, Homecare waiver services; 907 KAR 1:072, Payments for homecare waiver services; 907 KAR 1:090, Personal care assistance waiver services; and 907 KAR 1:092, Payments for personal care assistance waiver services; and 907 KAR 1:320, Kentucky Patient Access and Care System (KenPAC), are being repealed as those programs no longer exist.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation repeals 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 statues 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. The administrative regulation will affect the Department for Medicaid Services in that archaic and potentially contradictory policies will no longer be established in archaic administrative regulations.

(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 on 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 impacted 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 the administrative regulation. This administrative regulation authorizes the action being 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? 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.

(c) 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.

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
Division of Healthcare Facilities Management
(New Administrative Regulation)

907 KAR 3:225. Specialty intermediate care (IC) clinic service and coverage policies and requirements.

RELATES TO: KRS 205.520(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), and 205.520(3)

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 any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes Medicaid program service and coverage policies and requirements regarding specialty intermediate care clinic services.

Section 1. Definitions. (1) "1915(c) home and community based services waiver program" means a Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c).

(2) "Audiologist" is defined by KRS 334A.020(5).

(3) "Behavior Analyst Certification Board" means the nonprofit corporation:

(a) Established in 1998; and

(b) Known as the Behavior Analyst Certification Board®, Inc.

(4) "Board certified behavior analyst" means an individual who is currently certified by the Behavior Analyst Certification Board as a certified behavior analyst.

(5) "Clinical laboratory" means a medical laboratory pursuant to KRS 333.020(3).

(6) "Department" means the Department for Medicaid Services or its designee.

(7) "Developmental disability" means a severe chronic disability which:

(a) Is attributable to a mental or physical impairment or combination of mental and physical impairments manifested before the person attains the age of twenty-two (22);

(b) Is likely to continue indefinitely;

(c) Results in substantial limitations in three (3) or more areas of major life activity including:

1. Self-care;

2. Receptive and expressive language;

3. Learning;

4. Self direction;

5. Mobility; and

6. Capacity for independent living and economic sufficiency; and

(d) Requires individually planned and coordinated services of a lifelong or extended duration.

(8) "Enrollee" means an individual who is enrolled with a managed care organization for the purposes of receiving Medicaid program or KCHIP program covered services.

(9) "Epileptologist" means a physician who specializes in treating patients who have epilepsy.

(10) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(11) "Functional assessment" means an assessment per-

formed using evidenced-based tools, direct observation, and empirical measurement to obtain and identify functional relations between behavioral and environmental factors.

(12) "Licensed psychological associate" means an individual who is currently licensed in accordance with KRS 319.064.

(13) "Licensed psychological practitioner" means an individual who is currently licensed in accordance with KRS 319.053.

(14) "Licensed psychologist" means an individual who is currently licensed in accordance with KRS 319.050.

(15) "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.

(16) "Medically necessary" means determined by the department to be needed in accordance with 907 KAR 3:130.

(17) "Neurologist" means a physician who specializes in neurology.

(18) "Occupational therapist" is defined by KRS 319A.010(3).

(19) "Occupational therapist assistant" is defined by KRS 319A.010(4).

(20) "Ophthalmic dispenser" means an individual licensed to perform ophthalmic dispensing in accordance with KRS 326.030.

(21) "Ophthalmic dispensing" is defined by KRS 326.010(2).

(22) "Physical therapist" is defined by KRS 327.010(2).

(23) "Physical therapist assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy and related duties as assigned by the supervising physical therapist.

(24) "Physical therapy" is defined by KRS 327.010(1).

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

(26) "Physician services" means the practice of medicine or osteopathy provided by a physician.

(27) "Positive behavior support specialist" means an individual who:

(a) Provides:

1. Evidence-based individual interventions that assist a recipient with acquiring or maintaining skills for community living; and

2. Behavioral intervention to reduce maladaptive behaviors;

(b) Has a master's degree in a behavioral science and one (1) year of experience in behavioral programming; and

(c) Has at least one (1) year of direct services with individuals with an intellectual or developmental disability.

(28) "Practice of medicine or osteopathy" is defined by KRS 311.550(11).

(29) "Practice of psychology" is defined by KRS 319.010(6).

(30) "Primary care provider" means:

(a) A licensed primary care physician who is a:

1. Doctor of medicine or osteopathy; and

2. General practitioner, family practitioner, pediatrician, internist, obstetrician, or gynecologist;

(b) A licensed, certified advanced practice registered nurse who:

1. Has a "Collaborative Practice Agreement for Prescriptive Authority" in accordance with KRS 314.042; and

2. Has a signed written agreement with a primary care physician for backup twenty-four (24) hours per day seven (7) days a week for needed prescriptions and other primary care services outside the scope of practice of the advanced practice registered nurse;

(c) A physician group practice which bills the department using a group practice Medicaid provider number;

(d) A licensed primary care center operating under physician supervision which has at least one (1) full-time equivalent primary care physician who is a general practitioner, family practitioner, doctor of osteopathy, pediatrician, internist, obstetrician, or gynecologist;

(e) A licensed rural health clinic operating under physician supervision by a primary care physician who is a general practitioner, family practitioner, doctor of osteopathy, pediatrician, internist, obstetrician, or gynecologist; or

(f) A licensed physician specialist who is a doctor of medicine or osteopathy if the specialist agrees to serve as a primary care provider.

(31) "Psychiatrist" is defined by KRS 504.060(8).

(32) "Psychological services" means the practice of psychology.

(33) "Psychotropic medication" means a medication that is:

(a) Prescribed to treat the symptoms of a psychiatric disorder; or

(b) Utilized emergently to address psychiatric symptoms.

(34) "Recipient" is defined by KRS 205.8451(9).

(35) "Rural health clinic" is defined by 42 C.F.R. 405.2401(b).

(36) "Specialty intermediate care clinic" or "specialty IC clinic" means a clinic licensed pursuant to 902 KAR 20:410.

(37) "Speech-language pathologist" is defined by KRS 334A.020(3).

Section 2. Conditions of Participation. A specialty intermediate care clinic service shall be provided by an individual:

(1) Employed by a specialty intermediate care clinic; or

(2) Working for a specialty intermediate care clinic via a contractual agreement.

Section 3. Eligible Population. (1) To be eligible to receive specialty IC clinic services, an individual shall:

(a) Be a recipient:

(b) Have a mental illness, intellectual disability, or developmental disability; and

(c) Meet the patient status criteria established in:

1. Section 4(4) of 907 KAR 1:022; or

2. Section 4(5) of 907 KAR 1:022.

(2)(a) A recipient shall be eligible to receive services stated in Section 6 of this administrative regulation and in accordance with the requirements established in Section 6 of this administrative regulation if the recipient is:

1. Eligible in accordance with subsection (1) of this section;

2. Not receiving services via:

a. A 1915(c) home and community services waiver program; or

b. An intermediate care facility for individuals with an intellectual disability; and

3. Enrolled with a managed care organization.

(b) A recipient shall be eligible to receive services stated in Section 5 of this administrative regulation and in accordance with the requirements established in Section 5 of this administrative regulation if the recipient is:

1. Eligible in accordance with subsection (1) of this section;

2. Receiving services via:

a. A 1915(c) home and community services waiver program; or

b. An intermediate care facility for individuals with an intellectual disability; and

3. Not enrolled with a managed care organization.

Section 4. General Requirements Regarding Services. (1)(a) The department shall:

1. Reimburse for a specialty IC clinic service if the service was:

a. Medically necessary; and

b. Provided:

(i) By a specialty IC clinic; and

(ii) To an individual who is eligible to receive specialty IC clinic services pursuant to Section 3(1) and (2)(b) of this administrative regulation; or

2. Not reimburse for a specialty intermediate care clinic service if the service does not:

a. Meet the criteria established in paragraph (a) of this subsection; or

b. Comply with subsection (2) of this section.

(b) A managed care organization shall:

1. Reimburse for a specialty IC clinic service if the service was:

a. Medically necessary; and

b. Provided:

(i) By a specialty IC clinic; and

(ii) To an individual who is eligible to receive specialty IC clinic services pursuant to Section 3(1) and (2)(a) of this administrative regulation; or

2. Not reimburse for a specialty intermediate care clinic service if the service does not:

a. Meet the criteria established in paragraph (a) of this subsec-

tion; or

b. Comply with subsection (2) of this section.

(2) Services provided at a specialty IC clinic shall comply with the requirements established in 42 C.F.R. 440.90.

Section 5. Specialty Intermediate Care Clinic Services for Recipients Who are Not Enrolled with a Managed Care Organization. The following shall be the covered specialty intermediate care clinic services for an individual who is not enrolled with a managed care organization and who is eligible in accordance with Section 3(1) and (2)(b) of this administrative regulation:

(1) Dental services provided:

(a) By an authorized practitioner in accordance with 907 1:026; and

(b) In accordance with the limits established in 907 KAR 1:026;

(2) Psychiatric services provided:

(a) By a:

1. Psychiatrist; or

2. Physician; and

(b) In accordance with the psychiatric service limit established in 907 KAR 3:005;

(3) Psychological services provided by a licensed psychologist, licensed psychological practitioner, or licensed psychological associate;

(4) Psychotropic medication management provided by an advanced practice registered nurse, physician, or psychiatrist;

(5) Neurology services provided by a neurologist;

(6) Epileptology services provided by an epileptologist;

(7) Preventive health care;

(8) Primary and sub-specialist medical assessment and treatment;

(9) Occupational therapy provided:

(a) By an occupational therapist or occupational therapist assistant; and

(b) In accordance with the limits and requirements established in Section 6 of this administrative regulation;

(10) Physical therapy provided:

(a) By a physical therapist or physical therapist assistant; and

(b) In accordance with the limits and requirements established in Section 6 of this administrative regulation;

(11) Speech therapy provided:

(a) By a speech-language pathologist; and

(b) In accordance with the limits and requirements established in Section 6 of this administrative regulation;

(12) Nutritional or dietary consultation;

(13) Mobility evaluation or treatment;

(14) Positive behavioral support services which shall:

(a) Be the systematic application of techniques and methods to influence or change a behavior in a desired way;

(b) Be provided to assist a recipient to learn a new behavior that is directly related to existing challenging behaviors or a functionally equivalent replacement behavior for identified challenging behaviors;

(c) Include a functional assessment of the recipient's behavior which shall include:

1. An analysis of the potential communicative intent of the behavior;

2. The history of reinforcement for the behavior;

3. The critical variables that preceded the behavior;

4. The effects of different situations on the behavior;

5. A hypothesis regarding the motivation, purpose, and factors which maintain the behavior;

(d) Include the development of a positive behavioral support plan which shall:

1. Be developed by a behavioral support specialist:

2. Be implemented by staff in all relevant environments and activities;

3. Be revised as necessary at least once every six (6) months;

4. Define the techniques and procedures used;

5. Be designed to equip the recipient to communicate his or her needs and to participate in age-appropriate activities;

6. Include the hierarchy of behavior interventions ranging from the least to the most restrictive;

7. Reflect the use of positive behavioral approaches; and

8. Prohibit the use of prone or supine restraint, corporal punishment, seclusion, verbal abuse, or any procedure which denies private communication, requisite sleep, shelter, bedding, food, drink, or use of a bathroom facility;

(e) Include the provision of competency-based training to other providers concerning implementation of the positive behavioral support plan;

(f) Include the monitoring of a recipient's progress which shall be accomplished through:

1. The analysis of data concerning the frequency, intensity, and duration of behavior; and

2. The reports of a provider involved in implementing the positive behavioral support plan;

(g) Provide for the design, implementation, and evaluation of systematic environmental modifications;

(h) Be provided by a behavioral support specialist; and

(i) Be documented by a detailed staff note which shall include:

1. The date of the service;

2. The beginning and end time;

3. The signature, date of signature, and title of the behavior support specialist;

(15) Audiology provided by an audiologist and in accordance with the following:

(a) The limits established in 907 KAR 1:038 for services provided to an individual under the age of twenty-one (21) years shall be the limits for audiology services provided in a specialty intermediate care clinic regardless of the recipient's age; and

(b) The restriction established in 907 KAR 1:038 of not covering audiology services for an individual who is at least twenty-one (21) years of age shall not apply to audiology services provided in a specialty intermediate care clinic;

(16) Ophthalmic dispensing provided by an ophthalmic dispenser;

(17) A prescribed drug covered in accordance with 907 KAR 1:019;

(18) Medication consultation;

(19) Medication management;

(20) Seizure management;

(21) Diagnostic services;

(22) Clinical laboratory services;

(23) Physician services in accordance with the limits and requirements established in
907 KAR 3:005; or

(24) Laboratory services in accordance with the limits and requirements established in 907 KAR 1:028.

Section 6. Specialty Intermediate Care Clinic Services for Recipients Who are Enrolled with a Managed Care Organization. The following shall be the covered specialty intermediate care clinic services for an individual who is enrolled with a managed care organization and who is eligible in accordance with Section 3(1) and (2)(a) of this administrative regulation:

(1) Dental services provided in accordance with 907 KAR 1:026 except that a dentist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(2) Physicians services provided in accordance with 907 KAR 3:005 except that:

(a) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(3) Psychiatric services provided in accordance with 907 KAR 3:005 except that:

(a) A psychiatrist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(b) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(c) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(4) Behavioral health services in accordance with:

(a) 907 KAR 1:054 except that:

1. A clinical psychologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

2. An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(b) 907 KAR 1:082 except that:

1. A clinical psychologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

2. An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(c) 907 KAR 1:044 except:

1. That:

a. A clinical psychologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

b. A psychiatrist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

c. An advanced practice registered nurse who is certified in the practice of mental health nursing, meets the requirements of 201 KAR 20:057, and who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; and

2. For the following which shall not be covered if provided by a specialty IC clinic:

a. Inpatient services;

b. Therapeutic rehabilitation services for adults;

c. Therapeutic rehabilitation services for children; or

d. Services in a detoxification setting;

(5) Audiology services provided in accordance with 907 KAR 1:038 except that an audiologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(6) Ophthalmic dispensing provided by an ophthalmic dispenser in accordance with 907 KAR 1:038 except that an ophthalmologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(7) A prescribed drug covered in accordance with 907 KAR 1:019 except that a pharmacist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(8) Preventive health care in accordance with 907 KAR 3:005 except that:

(a) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(9) Occupational therapy in accordance with 907 KAR 3:005 except that an:

(a) Occupational therapist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) Occupational therapy assistant who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(10) Physical therapy in accordance with 907 KAR 3:005 except that a:

(a) Physical therapist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) Physical therapist assistant who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(11) Speech therapy in accordance with 907 KAR 3:005 except that a speech language pathologist who is an employee of or under contract with a specialty IC clinic shall be authorized to provide the services;

(12) Diagnostic services in accordance with 907 KAR 1:014, 907 KAR 1:054, 907 KAR 1:082, or 907 KAR 3:005 except that:

(a) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(13) Laboratory services in accordance with 907 KAR 1:028 except that if a specialty IC clinic's laboratory does not meet the requirements of 907 KAR 1:028, the specialty IC clinic shall be authorized to provide the services via a contractual relationship with a laboratory which meets the requirements of 907 KAR 1:028.

Section 7. Therapy Limits. (1) To be reimbursable by the department, occupational therapy, physical therapy, or speech therapy shall be limited to thirty (30) visits per twelve (12) months for a recipient except as established in subsection (1) of this section.

(2) The therapy limits established in subsection (1) of this section shall:

(a) Not apply to a recipient under twenty-one (21) years of age; and

(b) Be overridden by the department if the department determines that an additional visit or visits beyond the limit are medically necessary.

Section 8. No Duplication of Service. (1) The department shall reimburse no more than one (1) provider for the provision of a given service to a recipient on a given day.

(2) There shall be no duplicate billing to the department regarding a given service provided to a recipient on a given day.

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 federal financial participation for the policy; or

(2) Disapproves the policy.

Section 10. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: April 15, 2013

FILED WITH LRC: May 8, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@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 Medicaid specialty intermediate care (IC) clinic service and coverage policies and requirements.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid policies and requirements for specialty IC clinic services related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate-care facilities for individuals with an intellectual disability (ICF-IID) as a means of serving individuals in the most integrated setting appropriate to their needs.

(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 policies and requirements for specialty IC clinic services.

(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 establishing Medicaid policies and requirements for specialty IC clinic services.

(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: Affected individuals include Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability but who may be able to transition to a community setting as a result of this administrative regulation; individuals who are participating in a 1915(c) home and community based waiver program; and individuals who are neither of the aforementioned two (2) populations but are enrolled with a managed care organization. Additionally, the clinics themselves will be affected. One (1) facility, located in Louisville, has already been constructed and the start of construction for another facility, in Somerset, Kentucky, is anticipated to begin in June 2013.

(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: If a given specialty IC clinic wishes to be reimbursed by Medicaid for services provided to Medicaid recipients, the clinic will have to comply with the service requirements, practitioner requirements (including practitioner qualifications), and be licensed as a specialty IC clinic.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability; are receiving services via a 1915(c) home and community based waiver program; or are neither of the two (2) aforementioned but are enrolled with a managed care organization would benefit by being able to receive these outpatient clinic services.

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

(a) Initially: The Department for Medicaid Services estimates that implementing this administrative regulation will cost DMS $600,000 per month (state and federal combined) for each month of implementation in state fiscal year 2013.

(b) On a continuing basis: DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

(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 the Social Security Act, Title XIX and matching funds from state general 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 increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the regulated entities are regulated uniformly by this 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 impacted by this administrative regulation? The Department for Medicaid Services (DMS) and the Department for Behavioral Health, Developmental and Intellectual Disabilities 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. 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? DMS projects no revenue will be generated by the administrative regulation.

(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? DMS projects no revenue will be generated by the administrative regulation.

(c) How much will it cost to administer this program for the first year? DMS estimates that implementing this administrative regulation will cost DMS $600,000 per month (state and federal combined) for each month of implementation in state fiscal year 2013.

(d) How much will it cost to administer this program for subsequent years? DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

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. The mandate source is a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate-care facilities for individuals with an intellectual disability as a means of serving individuals in the most integrated setting appropriate to their needs.

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. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate-care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Healthcare Facilities Management
(New Administrative Regulation)

907 KAR 3:230. Reimbursement policies and requirements for specialty intermediate care (IC) clinic services.

RELATES TO: KRS 216B.450 through 459, 42 C.F.R. Part 413, 42 C.F.R. 447.204, 42 C.F.R. 447.321

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), and 205.560(2)

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 any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the reimbursement policies and requirements for covered specialty intermediate care clinic services provided to a Medicaid recipient who is not enrolled with a managed care organization and optional policies for covered specialty IC clinic services provided to a Medicaid recipient who is enrolled with a managed care organization.

Section 1. Definitions. (1) "Bad debt" means accounts receivable which will likely remain uncollected.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(4) "Government Auditing Standards" means the standards:

(a) For audits of government organizations, programs, activities, functions, and of government assistance received by contractors, nonprofit organizations, and other nongovernment organizations;

(b) Often referred to as generally accepted government auditing standards or GAGAS; and

(c) Accessible at the Web site of http://www.gao.gov/govaud/ybk01.htm.

(5) "Medically necessary" means determined by the department to be needed in accordance with 907 KAR 3:130.

(6) "Recipient" is defined by KRS 205.8451(9).

(7) "Specialty intermediate care clinic" or "specialty IC clinic" means a clinic located on the grounds of a state-owned facility licensed pursuant to 902 KAR 20:086 as an intermediate care facility for individuals with an intellectual disability.

Section 2. Interim Reimbursement. (1)(a) Except for a specialty IC clinic's first fiscal year of operation, the department shall reimburse on an interim basis:

1. For specialty intermediate care clinic services via an interim rate and utilizing a clinic-specific cost-to-charge ratio:

a. For each service;

b. Based on the clinic's most recently filed cost report, unless no cost report exists; and

c. Expressed as a percent of the clinic's charges; and

2. During the course of a state fiscal year until the most recent full fiscal year cost report from the clinic has been finalized by the department.

(b) The department shall use projected costs to establish interim rates for the first fiscal year of a specialty IC clinic's operation.

(2) The department shall determine a:

(a) Clinic-specific cost-to-charge ratio for each service; and

(b) Specialty IC clinic's interim rate for a service by:

1. Multiplying the total charges for the service by the service-specific cost-to-charge ratio; and

2. Dividing the number established pursuant to subparagraph 1. of this paragraph by the applicable number of service units. For example, $500,000 in total charges multiplied by a cost-to-charge ratio of 0.95 divided by 10,000 units equals an interim rate of forty-seven (47) dollars and fifty (50) cents.

(3) An interim rate for a fiscal year shall be effective on July 1 of a calendar year and remain in effect until close of business June 30 of the subsequent calendar year.

(4)(a) The department shall adjust an interim rate if:

1. The department miscalculated a specialty IC clinic's interim rate;

2. A specialty IC clinic submits an amended cost report which applies to the interim rate period; or

3. A further desk or on-site audit of a cost report used to establish the interim rate discloses a change in allowable costs.

(b) The department shall not adjust an interim rate for a reason not described in paragraph (a)1, 2, or 3 of this subsection.

(5) The department shall use the most recently received ICF-IID and Specialty Intermediate Care Clinic Cost Report as of March 15 to establish interim rates for a specialty IC clinic to be effective on July 1 of a given year.

Section 3. Final Reimbursement. (1) After the most recent full fiscal year cost report for a specialty IC clinic has been finalized by the department, the department shall cost settle with the clinic to establish final reimbursement to the clinic for the corresponding fiscal year.

(2) A cost settlement between the department and a specialty IC clinic shall:

(a) Be limited to an amount, if any, by which the specialty IC clinic's allowable costs exceeds the amount of:

1. Any third party recovery during the fiscal year; and

2. Interim payments made to the specialty IC clinic; and

(b) Not exceed the federal upper payment limit in accordance with 42 C.F.R. 447.321.

(3)(a) The department's reimbursement to a specialty IC clinic shall be payment in full to the specialty IC clinic for services provided to recipients.

(b) A specialty IC clinic shall not bill a recipient for a service provided to a recipient.

(c) A bad debt shall not be:

1. An allowable cost; or

2. Reimbursable by the department.

Section 4. Cost Reporting Requirements. (1)(a) A specialty IC clinic shall annually submit to the department a fully completed ICF-IID and Specialty Intermediate Care Clinic Cost Report within four (4) calendar months of the end of the prior state fiscal year.

(b) For example, an ICF-IID and Specialty Intermediate Care Clinic Cost Report covering the fiscal year ending June 30, 2013 shall be submitted to the department by close of business October 31, 2013.

(2) A specialty IC clinic shall complete an ICF-IID and Specialty Intermediate Care Clinic Cost Report in accordance with the ICF-IID and Specialty Intermediate Care Clinic Cost Report Instructions.

(3) Interim reimbursement for a specialty IC clinic which does not submit a legible and complete ICF-IID and Specialty Intermediate Care Clinic Cost Report to the department within the time

period referenced in subsection (1) of this section shall be placed in escrow by the department until the department receives a legible and completed ICF-IID and Specialty Intermediate Care Clinic Cost Report.

(4) After finalizing the first full fiscal year cost report submitted by a facility, the department shall establish an interim rate based on the first full year cost report.

(5)(a) An ICF-IID and Specialty Intermediate Care Clinic Cost Report shall include the statement stated in paragraph (b) of this subsection and the statement shall immediately precede the dated signature of the specialty IC clinic's administrator or chief financial officer.

(b) "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Kentucky Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were reported in compliance with such laws and regulations. This cost report includes total computable cost incurred to provide Medicaid services."

(6) If a cost report indicates a payment is due by a specialty IC clinic to the department, the specialty IC clinic shall submit the amount due or submit a payment plan request with the cost report.

(7) If a cost report indicates a payment is due by a specialty IC clinic to the department and the specialty IC clinic fails to remit the amount due or request a payment plan, the department shall suspend future payment to the specialty IC clinic until the specialty IC clinics remits the payment or submits a request for a payment plan.

(8)(a) If it is determined that an additional payment is due by a specialty IC clinic after a final determination of cost has been made by the department, the additional payment shall be due by the specialty IC clinic to the department within sixty (60) days after notification.

(b) If a specialty IC clinic does not submit the additional payment within sixty (60) days, the department shall withhold future payment to the specialty IC clinic until the department has collected in full the amount owed by the specialty IC clinic to the department.

(9)(a) A specialty IC clinic shall report all of its costs, allowable costs, and unallowable costs on a cost report.

(b) The department shall not reimburse for or cost settle unallowable costs.

Section 5. Allowable and Unallowable Costs. (1) An allowable cost shall:

(a) Be allowable in accordance with 42 C.F.R. Part 413;

(b) Be a cost allowed after an audit by the department; and

(c) Include:

1. A cost incurred by a specialty IC clinic in meeting and maintaining health standards pursuant to 42 C.F.R. 431.610(c); and

2. Costs resulting from meeting Kentucky specialty clinic licensure requirements pursuant to 902 KAR 20:410.

(2) Reimbursable services shall be the specialty IC clinic services established in 907 KAR 3:225.

(3) Costs relating to unallowable clinic activities shall:

(a) Be excluded from any cost settlement;

(b) Not be reimbursable; and

(c) Be reported separately on a cost report.

Section 6. Audits. (1) An ICF-IID and Specialty Intermediate Care Clinic Cost Report and all related documents submitted to the department by a specialty IC clinic shall be subject to audit, review, and reconciliation by the department.

(2) An audit, if performed, shall be performed in accordance with the most current Government Auditing Standards available via the Web site of http://www.gao.gov/govaud/ybk01.htm.

Section 7. Pharmacy, Medication, Immunization, and Other Costs Not Reimbursed at Cost. (1) The department shall reimburse for:

(a) Prescription drug costs experienced by a specialty IC clinic through the department's pharmacy program in accordance with 907 KAR 1:018; or

(b) Immunization costs experienced by a specialty IC clinic through the department's physicians' program in accordance with 907 KAR 3:010.

(2) Medication:

(a) Consultation costs shall be allowable; and

(b) Management costs shall be allowable.

Section 8. Not Applicable to Managed Care Organizations. (1) A managed care organization may elect to reimburse for specialty IC clinic services in accordance with this administrative regulation.

(2) The reimbursement policies established in this administrative regulation shall not apply to a managed care organization.

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 federal financial participation for the policy; or

(2) Disapproves the policy.

Section 10. Appeals. (1) An interim rate adjustment or denial of an interim rate adjustment may be appealed in accordance with 907 KAR 1:671.

(2) A Medicaid program sanction or appeal shall be in accordance with 907 KAR 1:671.

Section 11. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "ICF-IID and Specialty IC Clinic Cost Report", March 2013 edition; and

(b) "ICF-IID and Specialty IC Clinic Cost Report Instructions", March 2013 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 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: April 15, 2013

FILED WITH LRC: May 8, 2013 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 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 June 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 July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@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 Medicaid reimbursement policies and requirements for specialty intermediate care (IC) clinic services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference

into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

(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 reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights.

(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 reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights.

(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: Affected individuals include Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability but who may be able to transition to a community setting as a result of this administrative regulation. Additionally, any Medicaid recipients already living in a community setting and who need specialty IC clinic services could be affected. Lastly, the clinics themselves will be affected. One (1) facility, located in Louisville, has already been constructed and the start of construction for another facility, in Somerset, Kentucky, is anticipated to begin in June 2013.

(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: Specialty IC clinics will have to annually submit an ICF-IID and Specialty Intermediate Care Clinic Cost Report to DMS in order to be reimbursed for specialty IC clinic services provided to Medicaid recipients.

(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 the regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability but who may be able to transition to a community setting as a result of this administrative regulation would benefit. Additionally, any Medicaid recipients already living in a community setting and who need specialty IC clinic services could benefit by the expanded access to services.

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

(a) Initially: The Department for Medicaid Services estimates that implementing this administrative regulation will cost DMS $600,000 per month (state and federal combined) for each month of implementation in state fiscal year 2013.

(b) On a continuing basis: DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

(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 the Social Security Act, Title XIX and matching funds from state general 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 increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the regulated entities are regulated uniformly by this 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 impacted by this administrative regulation? The Department for Medicaid Services and the Department for Behavioral Health, Developmental and Intellectual Disabilities 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. This administrative regulation is necessary to establish Medicaid reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

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? DMS projects no revenue to be generated by the administrative regulation.

(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? DMS projects no revenue to be generated by the administrative regulation.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services estimates that implementing this administrative regulation will cost DMS $600,000 (state and federal combined) for each month of implementation in state fiscal year 2013.

(d) How much will it cost to administer this program for subsequent years? DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

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. The mandate source is a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics

on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

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. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

ADMINISTRATIVE REGULATION REVIEW SUBCOMMITTEE
Minutes of MAY 14, 2013

Call to Order and Roll Call

The May 2013 meeting of the Administrative Regulation Review Subcommittee was held on Tuesday, May 14, 2013, at 1:00 p.m., in Room 149 of the Capitol Annex. Senator Ernie Harris, Co-chair, called the meeting to order, the roll call was taken. The minutes of the April 2013 meeting were approved.

Present were:
Members: Senators Joe Bowen, Sara Beth Gregory, Ernie Harris, and Perry B. Clark, and Representatives Johnny Bell, Robert Damron, Tommy Turner, and Jimmie Lee.

LRC Staff: Dave Nicholas, Donna Little, Emily Caudill, Sarah Amburgey, Emily Harkenrider, Karen Howard, Betsy Cupp, and Laura Napier.

Guests: Representative John Will Stacy; Gilda Hill, Ken Lucas, Department of Veterans' Affairs; Michael Burleson, Board of Pharmacy; Nathan Goldman, Board of Nursing; Margaret Everson, Karen Waldrop, Kentucky Fish and Wildlife Resources; Amy Barker, Department of Corrections; Dana Todd, Department of Criminal Justice Training; Virginia Carrington, Elizabeth Caywood, Christina Heavrin, Lawrence Kissner, Stuart Owen, Cabinet for Health and Family Services; Clifford Rippetoe, Kentucky State Fair Board; Nancy Galvani, Kentucky Hospital Association; Darlene Eakin, Kentucky Optometric Association; Nina Eisner, Kelli Reese, The Ridge Behavioral Health; Chris Slocum, Peter Harris, MHNET/Coventry Cares of Kentucky; and Steven McBride, Citizen.

The Administrative Regulation Review Subcommittee met on Tuesday, May 14, 2013, and submits this report:

The Subcommittee determined that the following administrative regulation did not comply with statutory requirements and was deficient:

CABINET FOR HEALTH AND FAMILY SERVICES: Department for Medicaid Services: Commissioner's Office: Managed Care

907 KAR 17:005 & E. Definitions for 907 KAR Chapter 17. Christina Heavrin, general counsel; Lawrence Kissner, commissioner; and Stuart Owen, regulation coordinator, represented the department. Peter Harris, MD, PhD., and Chris Slocum, VP, Clinical Services, represented MHNet and testified via teleconference in support of this administrative regulation. Nancy Galvagni, Kentucky Hospital Association; Nina Eisner, CEO, The Ridge Behavioral Health; and Kelli Reese, director of admissions and utilization review, The Ridge Behavioral Health, appeared in opposition to this administrative regulation.

Representative Damron stated his rationale for his proposed amendments to this administrative regulation. Coventry Life Insurance owned MHNet; therefore, the insurance company was determining medical necessity payments to its own providing firm. Many MCOs were still owed money. The criteria used by MHNet is an entirely different system than that used by most providers, and it drives up healthcare costs. The use of the criteria by the same company that developed it did not provide a level playing field in Kentucky. His amendment would specifically require recognition of Interqual or Milliman Care Guidelines as the nationally recognized standards of care and written criteria.

Dr. Harris, testifying via teleconference, stated that MHNet's program was developed by providers and providers were still part of MHNet's administration. MHNet's medical necessity criteria was available online and had been scientifically validated. Providers made the final decision regarding medical care. MHNet differed from other programs in that its medical necessity criteria were never commercially available, though publicly accessible for review online. The criteria had been in place for sixteen (16) years, and the criteria was state specific, as appropriate. Criteria could be modified as necessary because other entities were not involved in establishing the standards. Dr. Harris asked the Subcommittee to oppose the proposed amendment to change the definition for "nationally-recognized standards of care and written criteria."

Mr. Slocum stated that problems with the medical necessity criteria could be addressed by modification of the criteria if the criteria continued to be solely established by MHNet. In response to questions by Representative Damron, Mr. Slocum stated that MHNet was owned by Coventry Life Insurance and profits for MHNet were reported to Coventry Life Insurance.

Ms. Galvagni stated that MHNet's medical necessity criteria were not comparable to Interqual's criteria. The Kentucky Hospital Association was opposed to a nonnational standard.

Ms. Eisner stated that MHNet experienced more denials and readmissions than more objective medical necessity criteria. She stated that even MHNet's representative, Dr. Harris, described the criteria as a "guide." MHNet did not update criteria, while Interqual had made many revisions. Readmission rates were double with MHNet compared to all other MCOs combined.

Ms. Reese stated that some cases that were denied pursuant to MHNet's criteria were approved pursuant to Interqual standards. MHNet's criteria provided more flexibility, but sometimes resulted in different answers from different MHNet representatives because of interpretation differences.

In response to a question by Senator Bowen, Ms. Eisner stated that other MCOs used Interqual. Dr. Harris stated that MHNet's criteria were revised as necessary and were available online for review. Interqual was inflexible to unique patient needs. Mental health was a nuanced science. Physician providers made final medical decisions.

Co-Chair Bell stated that the MHNet system limited access. Patients did not get appropriate treatment at first application; therefore, readmission rates were higher. MCOs were not getting paid in a timely fashion. In response, Dr. Harris stated that each patient was unique, and the more flexible standards were appropriate. For example, not all patients who discussed suicide frequently needed to receive inpatient treatment. Outpatient treatment was still appropriate on a case-by-case basis. Partnership between the insurer and the provider was a better system than an adversarial system. In response, Co-Chair Bell stated that treatment for a patient frequently discussing suicide should not be limited by financial motives. Dr. Harris stated that sometimes inpatient treatment was worse for a patient than outpatient care.

Mr. Slocum stated that the readmission rate for Medicaid was double that of patients with other payors generally.

In response to a question by Senator Bowen, Dr. Harris stated that other states were not restricted to Interqual criteria. Some states had specific criteria, especially pertaining to substance abuse treatment.

Representative Lee stated that readmission rates were not all of the same acuity. The comparison was not a direct one. Criteria should be established by contractual agreement or by statute, not by administrative regulation.

Ms. Heavrin stated that the cabinet had approved the criteria established in all MCO contracts. Kentucky's Region 3 used the Milliman Cure Guidelines rather than Interqual. Mr. Kissner stated that Coventry Life Insurance had been purchased by Aetna. The cabinet did not agree to the amendment to revise the definition of "nationally-recognized standards of care and written criteria."

Co-Chair Bell stated that the cabinet's function was to protect the health of Kentucky's citizens in an efficient manner. The cabinet had a fiduciary duty to the Commonwealth, and was responsible for balancing treatment against cost. Youth with mental conditions were being incarcerated at an alarming rate because individuals did not meet treatment criteria. MCOs had destroyed mental health access in Glasgow and Barren County. Many providers had not received payment for eight (8) or nine (9) months. The cabinet did not appear to be fulfilling its statutory function.

In response to questions by Co-Chair Bell, Ms. Heavrin stated that the Department of Insurance approves MCOs, which were required to have certain reserves to ensure against bankruptcy. Mr. Kissner stated that further questions regarding reserves should be

addressed to the Department of Insurance; however, Kentucky required 100 percent risk-based capital reserves.

A motion was made and seconded to approve the following amendments: to amend Section 1 to: (1) clarify that an "authorized representative" includes, for an enrollee who is authorized by Kentucky law to provide written consent, an individual or entity acting on behalf of, and with written consent from, an enrollee; or a legal guardian; and (2) comply with the drafting 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 Section 1 to insert a definition for "nationally-recognized standards of care and written criteria" and to renumber subsequent subsections accordingly. Because the agency did not agree to these amendments, the Subcommittee could not approve the amendments.

A motion was made and seconded to find 907 KAR 17:005, as amended, deficient. A roll call vote was conducted. With six (6) votes in favor of a finding of deficiency, two (2) votes opposed to a finding of deficiency, and one abstention, this administrative regulation as amended by the first amendment was found deficient.

Administrative Regulations Reviewed by the Subcommittee:

GOVERNOR'S OFFICE: Kentucky Department of Veterans' Affairs: Office of Kentucky Veterans' Centers: State Veterans' Nursing Homes

17 KAR 3:010. Calculation of resident charges at state veterans' nursing homes. Gilda Hill, executive director; Ken Lucas, commissioner; and Dennis Shepherd, attorney, represented the department.

In response to questions by Representative Damron, Ms. Hill stated that these administrative regulations did not change the maximum charge of $3,700, which was raised in 2012 in another administrative regulation. If residents qualified for Medicare or Medicaid, those residents would be asked to apply for those programs and the billing would be directed accordingly. Contract nurses were used if facilities were short staffed, such as during influenza and vacation seasons, and overtime was limited as much as practicable. Waiting lists at East and West were shorter than the waiting list for Thomas Hood. The department strove to maintain a good staffing ratio. Masser training was still provided as the department was financially able and as time permitted. Mr. Lucas stated that JECVO (Joint Executive Council of Veterans' Organizations) had previously been concerned about the stigma of veterans being classified as Medicare or Medicaid eligible and that the changes might allow nonveterans to become residents in these facilities. A Kentucky statute prohibited nonveterans, except for spouses of veterans, from being residents in these facilities. Although the statute authorized spouses of veterans to be residents at these facilities, it was not a requirement, and the department had not made provision for spouses of veterans to become residents of these facilities.

In response to questions by Representative Lee, Ms. Hill stated that, when the plans were completed, the department expected 100 percent of beds to be classified as Medicare and Medicaid certified. Self-payors could stay in any bed, regardless of Medicare and Medicaid certification of the bed. The department did not foresee future problems of bed shortages for self-payors because beds were available on a first come-first served basis, not on payor classification.

A motion was made and seconded to approve the following amendments: (1) to amend Section 1(10) to make a technical correction for consistent formatting; and (2) to amend Section 7 to revise a form incorporated by reference. Without objection, and with agreement of the agency the amendments were approved.

17 KAR 3:040. Admission to state veterans' nursing homes.

GENERAL GOVERNMENT CABINET: Board of Pharmacy: Board

201 KAR 2:074. Pharmacy services in hospitals or other organized health care facilities. Michael Burleson, executive director, represented the board.

A motion was made and seconded to approve the following amendments: (1) to amend the STATUTORY AUTHORITY paragraph to add statutory citations; and (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Sections 1, 2, and 4 through 7 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 Nursing: Board

201 KAR 20:059. Advanced practice registered nurse controlled substances prescriptions. Nathan Goldman, general counsel, represented the board.

A motion was made and seconded to approve the following amendments: (1) to amend the STATUTORY AUTHORITY paragraph to include a statutory citation; 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.

201 KAR 20:500. Nurse licensure compact.

A motion was made and seconded to approve the following amendments: to amend Sections 2, 3, 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.

TOURISM, ARTS AND HERITAGE CABINET: Department of Fish and Wildlife Resources: Game

301 KAR 2:049. Small game and furbearer hunting and trapping on public areas. Margaret Everson, assistant attorney general, and Karen Waldrop, director, Wildlife Division, represented the department.

301 KAR 2:122. Seasons, methods, and limits for small game.

JUSTICE AND PUBLIC SAFETY CABINET: Department of Corrections: Office of the Secretary

501 KAR 6:070. Kentucky Correctional Institution for Women. Amy Barker, assistant general counsel, represented the department.

In response to a question by Co-Chair Bell, Ms. Barker stated that the department changed the units where services were located; therefore, the procedure needed to be revised accordingly. More inmate populations needed mental health services. There were two (2) facilities that housed females, but the facility in Pee-Wee Valley was the primary facility.

A motion was made and seconded to approve the following amendments: to amend Section 1 and the material incorporated by reference to clarify provisions 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.

Department of Criminal Justice Training: Kentucky Law Enforcement Council: Council

503 KAR 1:170. Career Development Program. Dana Todd, assistant general counsel, represented the council.

In response to questions by Representative Damron, Ms. Todd stated that, other than one (1) new certification, this administrative regulation was not an expansion of the program. This was a voluntary program, not tied to compensation. The council anticipated that the program would cost the agency approximately $1,000 per year. Ms. Todd stated that the council did not anticipate asking for more funding. This program was not tied to insurance surtax but another program administered by the agency was. In response, Representative Damron stated that the insurance surtax supported the agency as a whole, and this program was still an expense of the agency.

Senator Bowen verified the continuing agency cost stated in the Fiscal Note on State and Local Government.

A motion was made and seconded to approve the following amendments: (1) to amend Section 1 to add definitions for "public safety dispatch" and "public safety dispatcher"; (2) to amend the NE-

CESSITY, FUNCTION, AND CONFORMITY paragraph and Sections 17 and 18 to clarify provisions; and (3) to amend Sections 1, 2, 3, 9, and 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.

CABINET FOR HEALTH AND FAMILY SERVICES: Department for Medicaid Services: Division of Provider Operations: Medicaid Services

907 KAR 1:056E. Repeal of 907 KAR 1:418 and 907 KAR 1:427. Christina Heavrin, general counsel; Lawrence Kissner, commissioner; and Stuart Owen, regulation coordinator, represented the division.

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

Commissioner's Office: Managed Care

907 KAR 17:010 & E. Managed care organization requirements and policies relating to enrollees. Christina Heavrin, general counsel; Lawrence Kissner, commissioner; and Stuart Owen, regulation coordinator, represented the division. Peter Harris, MD, PhD., and Chris Slocum, VP, Clinical Services, represented MHNet and testified via teleconference in support of this administrative regulation. Nancy Galvagni, Kentucky Hospital Association; Nina Eisner, CEO, The Ridge Behavioral Health; and Kelli Reese, director of admissions and utilization review, The Ridge Behavioral Health, appeared in opposition to this administrative regulation.

In response to questions by Representative Lee, Mr. Kissner stated that the agency agreed to amendments proposed by Representative Lee to address written consent requirements. Ms. Galvagni stated that the Kentucky Hospital Association supported Representative Lee's amendments to this administrative regulation.

Representative Damron stated that, in 2012, the cabinet assured the General Assembly that problems with payments to providers would be quickly remedied. After fourteen (14) months, the matter remained unresolved. If the problems were not rectified before the 2014 Regular Session of the General Assembly, legislative directives would be proposed to address the situation.

A motion was made and seconded to approve the following amendments: (1) to amend Sections 1, 4, 5, 7, 8, 11, 13, 16, and 17 to comply with the drafting and formatting requirements of KRS Chapter 13A; (2) to amend Section 4 to clarify that: (a) a written appeal shall be signed by the enrollee or the enrollee's authorized representative; and (b) written notice that an appeal has been received and the expected date of resolution shall be sent to an enrollee's legal guardian or authorized representative, if applicable; (3) to amend Section 5 to specify that a document supporting an MCO's adverse action shall be received by the department no later than five (5) days from the date the MCO receives the notice, rather than five (5) days from the date a notice is sent to the MCO; (4) to amend Section 17 to specify that a child's caretaker may attend each meeting held to discuss the health care needs of that child; and (5) to amend Section 4(4)(b) to: (a) specify that: 1. for authorized representative purposes, written consent unique to an appeal or state fair hearing shall be required for the appeal or state fair hearing; and 2. a single written consent shall not qualify as written consent for more than one (1) hospital admission, physician or provider visit, or treatment plan; and (b) delete the provisions of paragraph (b), which would have required that written consent be signed and dated by the enrollee no earlier than the date of the MCO's action. Without objection, and with agreement of the agency, the amendments were approved.

Representative Damron withdrew the following proposed amendments: (1) to amend Section 4(4) to: (a) amend paragraph (a) to delete the requirement that the written consent be "for the specific action that is being appealed or that is the subject of state fair hearing"; and (b) delete the provisions of paragraph (b), which would have required that written consent be signed and dated by the enrollee no earlier than the date of the MCO's action; (2) to amend Section 5(1) to specify that a provider shall have a right to a state fair hearing administered by the department in accordance with KRS Chapter 13B to challenge an MCO's denial of coverage or payment for services rendered to a patient; (3) to amend references throughout Section 5 to correspond to that change; (4) to amend Section 6(3)(c) to require that an MCO facilitate direct access to a specialty provider, rather than specialty physician, for an enrollee with a chronic or complex health condition; who is aged, blind, deaf, or disabled; or identified as having a special healthcare need and requiring a course of treatment or regular healthcare monitoring; and (5) to amend Section 8(2)(c)1. to require that the MCO's member handbook specify the names and contact information for all other providers included in the MCO's network, rather than leaving the inclusion of that information for other providers to the discretion of the MCOs. Without objection, the proposed amendments were withdrawn.

907 KAR 17:015 & E. Managed care organization requirements and policies relating to providers. Representative John Will Stacy appeared in support of the amendment to this administrative regulation.

Representative Lee stated that he was proposing to amend Section 2 of this administrative regulation to use miles for measuring services in all regions except Region 3 and to use minutes or miles for measuring services in Region 3.

Representative Stacy stated that litigation on the matter of distance requirements was ongoing. In response to a question by Representative Stacy, Ms. Heavrin stated that the distance limit of sixty (60) minutes was established in the original contracts, which had already been submitted to CMS. MCOs used GEOAccess to determine distances.

In response to a question by Co-Chair Bell, Ms. Heavrin stated that the contracts were in place prior to this administrative regulation. Co-Chair Bell stated his belief that the agency had entered into a contract without authority because this administrative regulation was not in place upon the contractual agreement. In response to a question by Co-Chair Bell, Mr. Kissner stated that the division did not agree to defer consideration of this administrative regulation to the June Subcommittee meeting.

Ms. Galvagni stated that the Kentucky Hospital Association preferred a single standard for all regions of Kentucky, but could live with the amendment to this administrative regulation.

A motion was made and seconded to approve the following amendments: (1) to amend Sections 1, 2, 4, 7, 8, and 13 to comply with the drafting and formatting requirements of KRS Chapter 13A; (2) to amend Section 4 to specify the deadlines for obtaining accreditation from the National Committee for Quality Assurance (NCQA); and (3) to amend Section 2(7), 2(8), 2(9), 2(10), and 2(11) to specify that a hospital; behavioral or physical rehabilitation service; dental service; general vision, laboratory, or radiological service; or pharmacy service shall be within the specified number of: (a) miles for Regions 1, 2, 4, 5, 6, 7, or 8; or (b) minutes or miles for Region 3. With two (2) objections, and with agreement of the agency, the amendments were approved.

The following amendments, proposed by Representative Damron, were not considered: (1) to amend Section 2(7), 2(8), 2(9), 2(10), and 2(11) to delete the references to miles for a hospital; behavioral or physical rehabilitation service; dental service; general vision, laboratory, or radiological service; or pharmacy service; (2) to amend Section 2(10)(a) to delete the reference to miles for a general vision, laboratory, or radiological service; (3) to amend Section 4 to create a new subsection (5) to require an MCO to reimburse a provider for covered services beginning on the date the provider applied to be a provider for the MCO; and (4) to amend Section 11(2) to specify that a provider has the right to file a request for a state fair hearing.

907 KAR 17:020 & E. Managed care organization service and service coverage requirements and policies.

A motion was made and seconded to approve the following amendments: to amend Sections 4, 11, and 13 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 17:025 & E. Managed care organization requirements and policies related to utilization management and quality. Darlene Eakin, executive director, Kentucky Optometric Association, appeared in support of an amendment proposed by Representative Damron.

Ms. Eakin stated that the Kentucky Optometric Association was concerned about access. Nonoptometric providers did not always understand the scope of optometry.

Mr. Kissner stated that the division did not agree to Representative Damron's proposed amendment, which would require that a request based on optometry be reviewed by an optometrist.

A motion was made and seconded to find this administrative regulation deficient. A roll call vote was conducted. The motion was not approved.

A motion was made and seconded to approve the following amendments: to amend Sections 1 and 11 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendment was approved.

A motion was made and seconded to approve the following amendment: to amend Section 1(3) to specify that if a request is made by an enrollee or enrollee's treating optometrist, the 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 enrollee's optometrist shall be made by a Kentucky licensed optometrist. Without agreement of the agency, the amendment was not approved.

907 KAR 17:030 & E. Managed care organization operational and related requirements and policies.

Department for Community Based Services: Division of Family Support: K-TAP, Kentucky Works, Welfare to Work, State Supplementation

921 KAR 2:015 & E. Supplemental programs for persons who are aged, blind, or have a disability. Virginia Carrington, branch manager, and Elizabeth Caywood, policy analyst, represented the division.

The following administrative regulations were deferred to the June 11, 2013, meeting of the Subcommittee:

ENERGY AND ENVIRONMENT CABINET: Department for Environmental Protection: Division of Water: Water Quality Standards

401 KAR 10:030. Antidegradation policy implementation methodology.

PUBLIC PROTECTION CABINET: Department of Alcoholic Beverage Control: Quotas

804 KAR 9:040. Retail liquor package license quota.

804 KAR 9:050. Retail liquor drink license quota.

Department of Housing, Buildings and Construction: Division of Building Codes Enforcement: Kentucky Building Code

815 KAR 7:120. Kentucky Building Code.

OTHER BUSINESS:

TOURISM, ARTS AND HERITAGE CABINET: Kentucky State Fair Board: Board

303 KAR 1:041. Certain objects and attire prohibited on premises. Clifford Rippetoe, president and CEO of the Kentucky State Fair Board, represented the board. Steven McBride, citizen, appeared in opposition of this administrative regulation.

Mr. McBride stated that this administrative regulation was a violation of the Second Amendment to the Constitution of the United States. This administrative regulation had been in effect since 1978 and did not provide for the 1996 Kentucky Carry and Conceal statute. This administrative regulation was in violation of several statutes pursuant to KRS Chapter 13B. This administrative regulation was also onerous in regards to weapon searches.

Co-Chair Harris stated that only statutes, not administrative regulations, could provide requirements pertaining to weapons on state property. In response to a question by Co-Chair Harris, Mr. Rippetoe stated that the board agreed to defer consideration of this administrative regulation until the matter could be fully investigated. He stated that the board intended to amend this administrative regulation for compliance with all applicable law, federal and state, including provisions regarding weapon searches.

Without objection, and with agreement of the agency, the administrative regulation was deferred for consideration at the June Subcommittee meeting.

The Subcommittee adjourned at 3:15 p.m. until June 11, 2013 at 1 p.m.

OTHER COMMITTEE REPORTS

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.

NONE

CUMULATIVE SUPPLEMENT

Locator Index - Effective Dates L - 2

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 L - 12

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 L - 25

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 L - 26

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.

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 but had not yet gone into effect when the 12 bound Volumes were published.

SYMBOL 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:

(Note: Emergency regulations expire 180 days from the date filed; or 180 days from the date filed plus number of days of requested extension, or upon replacement or repeal, whichever occurs first.)

103 KAR 31:170E	1934	5-11-12
Replaced		(See 39 Ky.R.)
405 KAR 10:011E*(r)*	1935	5-4-12
Expired		10-31-12
405 KAR 10:015E	1937	5-4-12
Replaced		(See 39 Ky.R.)
921 KAR 2:015E	1429	12-29-11
Replaced	1969	6-20-12

ORDINARY ADMINISTRATIVE REGULATIONS:

11 KAR 3:100		
Amended	1977	(See 39 Ky.R.)
101 KAR 2:102		
Amended	1171	7-6-12
101 KAR 2:140		
Amended	1176	
As Amended	1944	7-6-12
101 KAR 3:015		
Amended	1178	7-6-12
103 KAR 8:010		
Amended	73	
As Amended	1297	
Withdrawn		10-31-12
103 KAR 31:170	2107	(See 39 Ky.R.)
106 KAR 2:030	2108	(See 39 Ky.R.)
201 KAR 8:562		
Amended	1870	(See 39 Ky.R.)
201 KAR 13:040		
Amended	1875	(See 39 Ky.R.)
201 KAR 18:220		
Amended	1991	8-31-12
201 KAR 20:450		
Amended	1994	(See 39 Ky.R.)
201 KAR 20:490		
Amended	1764	
As Amended	1945	6-20-12
201 KAR 20:510		
Amended	1997	8-15-12
201 KAR 23:015		
Amended	1767	
As Amended	1947	6-20-12
201 KAR 30:050		
Amended	1768	
As Amended	1947	7-6-12
201 KAR 32:035		
Amended	1877	(See 39 Ky.R.)
202 KAR 7:601		
Amended	1770	(See 39 Ky.R.)
301 KAR 1:201		
Amended	1783	6-7-12
301 KAR 1:410		
Amended	1788	
Amended	1974	(See 39 Ky.R.)
301 KAR 2:041		
Amended	1879	(See 39 Ky.R.)
301 KAR 2:049		
Amended	1883	(See 39 Ky.R.)
301 KAR 2:081		
Amended	1887	(See 39 Ky.R.)
301 KAR 2:082		
Amended	1893	(See 39 Ky.R.)
301 KAR 2:084		
Amended	1898	(See 39 Ky.R.)
301 KAR 2:300		
Amended	1899	(See 39 Ky.R.)
301 KAR 3:022		
Amended	1903	(See 39 Ky.R.)
301 KAR 2:251		
Amended	1661	
As Amended	1948	6-7-12
304 KAR 1:040		
Amended	2002	(See 39 Ky.R.)
304 KAR 1:080	2110	(See 39 Ky.R.)
405 KAR 10:015	2111	(See 39 Ky.R.)
405 KAR 10:030		
Amended	2004	(See 39 Ky.R.)
405 KAR 16:020		
Amended	2007	(See 39 Ky.R.)
501 KAR 6:020		
Amended	1905	(See 39 Ky.R.)
501 KAR 6:050		
Amended	2011	(See 39 Ky.R.)
501 KAR 6:090		
Repealed	1808	7-6-12
501 KAR 6:091*(r)*	1808	7-6-12
501 KAR 6:110		
Amended	2013	8-31-12
501 KAR 6:200		
Amended	1791	
As Amended	1951	7-6-12
501 KAR 6:240		
Amended	1793	
As Amended	1953	7-6-12
501 KAR 6:260	1916	(See 39 Ky.R.)
501 KAR 6:280	1918	(See 39 Ky.R.)
503 KAR 1:110		
Amended	1795	
As Amended	1953	7-6-12
503 KAR 3:070		
Amended	1665	
As Amended	1956	7-6-12
601 KAR 1:018		
Amended	1487	
As Amended	1957	7-6-12
601 KAR 1:019	1399	
As Amended	1962	7-6-12
702 KAR 1:160		
Amended	1799	(See 39 Ky.R.)
703 KAR 5:002*(r)*	1401	(See 39 Ky.R.)
703 KAR 5:070		
Amended	1907	(See 39 Ky.R.)
703 KAR 5:140		
Amended	1391	(See 39 Ky.R.)
703 KAR 5:220	707	
703 KAR 5:225	1919	(See 39 Ky.R.)
703 KAR 5:240	1407	(See 39 Ky.R.)
704 KAR 3:340		
Amended	1909	(See 39 Ky.R.)
704 KAR 5:070	1410	(See 39 Ky.R.)
803 KAR 2:300		
Amended	2016	8-31-12
803 KAR 2:307		
Amended	2018	8-31-12
803 KAR 2:309		

Amended	2021	8-31-12
803 KAR 2:313		
Amended	2023	(See 39 Ky.R.)
803 KAR 2:316		
Amended	2025	8-31-12
803 KAR 2:317		
Amended	2027	8-31-12
803 KAR 2:319		
Amended	2029	8-31-12
803 KAR 2:320		
Amended	2031	(See 39 Ky.R.)
803 KAR 2:403		
Amended	2037	8-31-12
803 KAR 2:405		
Amended	2040	(See 39 Ky.R.)
803 KAR 2:407		
Amended	2042	(See 39 Ky.R.)
803 KAR 2:425		
Amended	2044	(See 39 Ky.R.)
803 KAR 2:500		
Amended	2046	8-31-12
804 KAR 4:370		
Amended	2049	8-31-12
806 KAR 3:190		
Amended	1910	(See 39 Ky.R.)
810 KAR 1:018		
Amended	2052	(See 39 Ky.R.)
810 KAR 1:028		
Amended	2061	(See 39 Ky.R.)
810 KAR 1:040	2116	8-31-12
811 KAR 1:090		
Amended	2068	(See 39 Ky.R.)
811 KAR 1:093	2118	8-30-12
811 KAR 1:095		
Amended	2077	(See 39 Ky.R.)
811 KAR 2:093	2119	8-31-12
811 KAR 2:096		
Amended	2084	(See 39 Ky.R.)
811 KAR 2:100		
Amended	2093	(See 39 Ky.R.)
815 KAR 6:010		
Amended	1498	
Amended	1866	
As Amended	1966	7-6-12
815 KAR 6:070	1521	
As Amended	1968	
Withdrawn		6-8-12
815 KAR 20:100		
Amended	2099	8-31-12
900 KAR 7:030		
Amended	2102	8-31-12
900 KAR 9:010	2121	(See 39 Ky.R.)
921 KAR 2:015		
Amended	1501	
As Amended	1969	6-20-12
921 KAR 3:035		
Amended	1804	6-20-12

SYMBOL KEY:
* Statement of Consideration not filed by deadline
** 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

VOLUME 39

EMERGENCY ADMINISTRATIVE REGULATIONS:
(Note: Emergency regulations expire 180 days from the date filed; or 180 days from the date filed plus number of days of requested extension, or upon replacement or repeal, whichever occurs first.)

101 KAR 2:210	729	9-14-12
Replaced	813	1-4-13
103 KAR 3:040	1862	1-15-13
103 KAR 3:060E	942	9-27-12
Expires		3-26-12
103 KAR 5:220	730	9-4-12
Replaced	1653	3-8-13
103 KAR 31:170E		(See 38 Ky.R.)
Replaced	458	10-5-12
105 KAR 1:400E	4	5-30-12
Replaced	750	10-24-12
201 KAR 2:020E	378	7-20-12
Expired		1-16-13
201 KAR 2:030E	379	7-20-12
Expired		1-16-13
201 KAR 2:050E	381	7-20-12
Expired		1-16-13
201 KAR 2:061E	383	7-20-12
Expired		1-16-13
201 KAR 2:205E	385	7-20-12
Expired		1-16-13
201 KAR 2:350E	386	7-20-12
Expired		1-16-13
201 KAR 5:010E	388	7-20-12
Expired		1-16-13
201 KAR 5:030E	390	7-20-12
Expired		1-16-13
201 KAR 5:130E	392	7-20-12
Expired		1-16-13
201 KAR 8:532E	394	7-20-12
Expired		1-16-13
201 KAR 8:540E	398	7-25-12
Expired		1-21-13
201 KAR 9:001E	401	7-20-12
Expired		2-16-13
201 KAR 9:081E	402	7-20-12
Expired		1-16-13
201 KAR 9:200E	406	7-20-12
Expired		1-16-13
201 KAR 9:210E	408	7-20-12
Expired		1-16-13
201 KAR 9:220E	409	7-20-12
Expired		2-16-13
201 KAR 9:230E	410	7-20-12
Expired		1-16-13
201 KAR 9:240E	411	7-20-12
Expired		1-16-13
201 KAR 9:250E	414	7-20-12
Expired		1-16-13
201 KAR 9:260E	418	7-20-12
Expired		2-16-13
201 KAR 9:310E	423	7-20-12
Expired		1-16-13
201 KAR 20:056E	426	7-20-12
Expired		1-16-13
201 KAR 20:057E	429	7-20-12
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201 KAR 20:161E	431	7-20-12
Expired		1-16-13
201 KAR 20:215E	434	7-20-12
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201 KAR 25:011E	436	7-20-12
Expired		1-16-13
201 KAR 25:021E	438	7-20-12
Expired		1-16-13
201 KAR 25:031E	439	7-20-12
Expired		1-16-13
201 KAR 25:051E	441	7-20-12
Expired		1-16-13
201 KAR 25:090E	444	7-20-12

Regulation Number	38 Ky.R. Page No.	Effective Date
Expired		1-16-13
301 KAR 2:195E	1574	12-28-12
301 KAR 2:221E	1099	10-31-12
Replaced	1302	3-8-13
301 KAR 2:222E	1101	10-31-12
Replaced	1684	3-8-13
301 KAR 2:224E	1105	10-31-12
Replaced	1308	3-8-13
301 KAR 2:225E	773	8-27-12
Replaced	838	1-4-13
405 KAR 10:015E		(See 38 Ky.R.)
Replaced	467	9-6-12
502 KAR 10:120E	8	5-31-12
Replaced	478	10-2-12
900 KAR 6:075E	736	8-23-12
Replaced	1695	3-8-13
900 KAR 7:030E	1580	12-27-12
Replaced	1785	5-3-13
900 KAR 10:010E	2296	5-13-13
902 KAR 20:420E	446	7-20-12
Expired		2-16-13
902 KAR 55:015E	1584	12-19-12
Replaced	2032	5-3-13
902 KAR 55:110E	452	7-20-12
Expired		2-16-13
906 KAR 1:160E	182	7-13-12
Replaced	335	10-17-12
907 KAR 1:055E	1987	3-1-13
907 KAR 1:056E*(r)*	1993	3-1-13
907 KAR 1:711E	1587	12-21-12
907 KAR 3:015E	2112	4-3-13
907 KAR 3:225E	2301	5-8-13
907 KAR 3:230E	2306	5-8-13
907 KAR 9:005E	739	9-4-12
Replaced	1697	3-8-13
907 KAR 9:010E	746	9-4-12
Replaced	1704	3-8-13
907 KAR 14:005E	184	6-22-12
Replaced	1168	1-4-13
907 KAR 17:005E	1589	12-21-12
907 KAR 17:010E	1610	12-21-12
907 KAR 17:015E	1620	12-21-12
907 KAR 17:020E	1625	12-21-12
907 KAR 17:025E	1630	12-21-12
907 KAR 17:030E	1635	12-21-12
921 KAR 2:015E	1639	12-21-12
921 KAR 3:090E	2115	3-28-13
922 KAR 1:130E	2117	3-28-13
922 KAR 1:140E	2122	3-28-13
922 KAR 1:320E	2126	3-28-13
922 KAR 1:400E	2130	3-28-13
922 KAR 2:090E	2134	3-27-13
922 KAR 2:160E	2140	3-27-13
ORDINARY ADMINISTRATIVE REGULATIONS:		
11 KAR 3:100		(See 38 Ky.R.)
As Amended	187	8-31-12
11 KAR 4:080		
Amended	1748	5-3-13
11 KAR 8:030		
Amended	1271	
Withdrawn		1-8-13
13 KAR 1:020		
Amended	1043	
As Amended	1365	2-1-13
16 KAR 2:120		
Amended	66	
As Amended	456	9-10-12
16 KAR 3:010		
Amended	497	
As Amended	944	11-19-12
16 KAR 6:010		
Amended	1274	
As Amended	1646	3-8-13
16 KAR 6:030		
Amended	499	
As Amended	945	11-19-12
16 KAR 8:030		
Amended	1279	
As Amended	1649	3-8-13
17 KAR 3:010		
Amended	1897	
As Amended	2310	
17 KAR 3:040	1963	
40 KAR 2:330	350	
Amended	780	
As Amended	946	12-7-12
101 KAR 2:076		
Amended	2361	
101 KAR 2:095		
Amended	2362	
101 KAR 2:102		
Amended	2365	
101 KAR 2:210		
Amended	813	1-4-13
101 KAR 3:015		
Amended	2370	
101 KAR 3:050		
Amended	2375	
102 KAR 1:070		
Amended	1899	
As Amended	2149	
102 KAR 1:225		
Amended	1050	
As Amended	1371	2-1-13
102 KAR 1:230		
Amended	1749	
As Amended	1995	5-3-13
102 KAR 1:310		
Amended	1282	
As Amended	1651	3-8-13
102 KAR 1:320		
Amended	1901	
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102 KAR 1:340	1342	
As Amended	1652	3-8-13
102 KAR 1:350	1964	
As Amended	2152	
103 KAR 3:010		
Amended	1904	
103 KAR 3:030		
Amended	1910	
As Amended	2152	
103 KAR 3:040		
Amended	1920	
103 KAR 5:220	916	
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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.

‡ - A technical amendment was made during the promulgation process to this administrative regulation pursuant to KRS 13A.320(d).

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